COUNTWAY LIBRARY
3 2044 115 036 139

BOSTON
MEDICAL LIBRARY
8 THE FENWAY

Digitized by the Internet Archive
in 2016

https://archive.org/details/connecticutstate4194conn

The Connecticut State Medical Journal

BOSTON
MAR 7 1940
MEDICAL LIBRARY

FOUNDED IN 1792

148th ANNUAL MEETING
HOTEL BOND, HARTFORD
May 22 and 23, 1940

30223

VOLUME FOUR • JANUARY, 1940 • NUMBER ONE

THE CONNECTICUT STATE MEDICAL SOCIETY
THE CONNECTICUT HOSPITAL ASSOCIATION

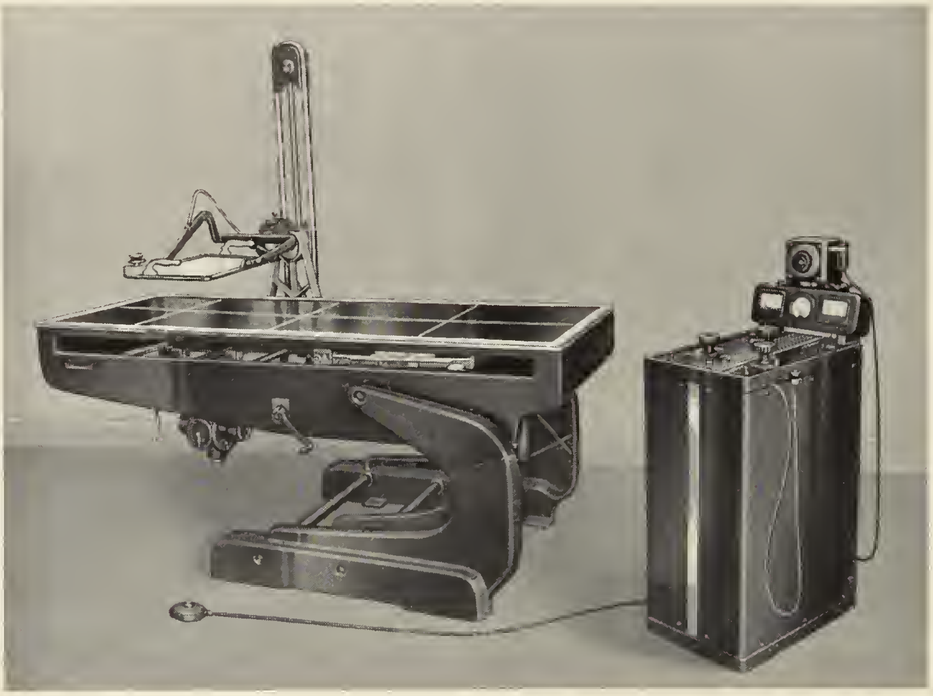
PER YEAR, $4.00
SINGLE COPIES, 50c

PROFESSIONAL EQUIPMENT CO.

36 HOWE ST. TELEPHONE 7-2138 NEW HAVEN, CONN.

KELEKET
X-Ray
Apparatus

6 Service
Men
On Call



One of Our New KELEKET Shock Proof Radiographic and Fluoroscopic Office Units.

THIS NEW UNIT OFFERS COMPLETENESS YET SIMPLICITY.
SUCCESS AND PRESTIGE ACCOMPANY INVESTMENT IN THIS SERVICE TO PATIENTS.

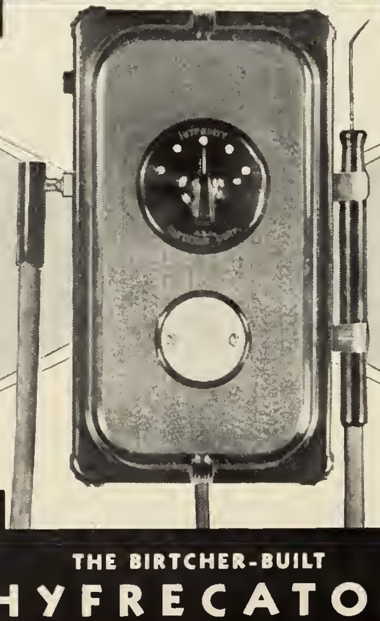
Permanently Removes Warts, Moles and Kindred Foreign Growths

QUICK, SIMPLE, SAFE
FINE COSMETIC EFFECT

Small growths removed in a matter of seconds with patient satisfaction assured through minimum discomfort and the excellence of the resultant cosmetic effect. Technique is extremely simple and fully outlined in booklet supplied with instrument.

A CLINICALLY TRIED
AND PROVEN METHOD

The finely controlled fulguration and desiccation currents as supplied by the Hyfrecator have been utilized for years for the permanent removal of foreign growths from the body surfaces and within accessible cavities.



Epilation Needles Available for the Removal of Superfluous Hair

Performs All Fulguration-Desiccation Techniques

THE BIRTCHER-BUILT
"HYFRECATOR"

Comes complete with footswitch, fulguration-desiccation needle, and detailed operating instructions at only $37.50

PROFESSIONAL EQUIPMENT CO., NEW HAVEN

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1939-1940) . . . 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) . . . 5

ORIGINAL PAPERS:

Industrial Poisons — Physiological and Pathological Considerations
George H. Gehrmann, M.D., Wilmington, Delaware 3

Legg-Perthe Disease with Particular Regard to Treatment
Maurice M. Pike, M.D., Hartford, Conn. 5

Present Trend in Treatment of Progressive Deafness —
Norton Canfield, M.D., New Haven, Conn. 12

Treatment Procedures for Cancer of Uterus Advised by The Connecticut Tumor Clinics —
James Raglan Miller, M.D., Hartford, Conn. 16

Dysmenorrhea . . . Carl E. Johnson, M.D., New Haven, Conn. 20

Summary of Gynecological and Obstetrical Papers —
John Fraser, M.D., Montreal Canada 23

Further Studies in Therapy of Acute Anterior Poliomyelitis —
C. L. Thenebe, M.D., and M. S. Hirshberg, M.D., Hartford, Conn. 25

EDITORIALS:

Industrial Pathogensis . . . 29
Enter — The Connecticut Hospital Association . . . 30
Medical Necromancy . . . 30
Federal Grants . . . 31
Attention Advertisers! . . . 31
The Achilles Heel . . . 32

FROM THE SECRETARY'S OFFICE . . . 33

CONNECTICUT HOSPITAL ASSOCIATION:

A Bristol Hospital Problem . . . 34
Greenwich Hospital Development Plans . . . 34
Torrington Has An Active Women's Auxiliary . . . 34
Report of Semi-Annual Meeting . . . 35

GENERAL PRACTITIONER'S FORUM . . . 40

OUR NEIGHBORS . . . 41

NEWS FROM COUNTY ASSOCIATIONS . . . 42

SPECIAL NOTICES . . . 46

LETTERS TO THE EDITOR . . . 48

OBITUARIES:

James Edward Murphy, M.D. . . . Ralph deB. Clarke, M.D. 50

QUARTO NOTES (Book Review) . . . 50

1940

The 4th

consecutive year of advertising

in Journal of

the Connecticut State

Medical Society

ELI LILLY AND COMPANY

PRESIDENT

CONNECTICUT HOSPITAL ASSOCIATION

Wilmar Mason Allen, M.D.

Director, Hartford Hospital

The Connecticut State Medical Journal

Vol. IV. JANUARY, 1940 No. 1

Industrial Poisons — Physiological and Clinical Considerations*

GEORGE H. GEHRMANN, M.D., F.A.C.P.,**
Wilmington, Del.

In industry today hundreds of thousands of compounds are being utilized daily and it is now felt that all compounds are toxic in some degree. Consequently, the diseases which arise from contact with industrial poisons are as legion as are the poisons themselves. Industrial medical service today, contrary to popular belief, is not concerned with surgical problems alone, which constitute but a small part of the industrial physician's interests, but with disease in its manifold manifestations.

The broad field involving diagnosis, treatment and prevention demands knowledge of the working conditions affecting the individual's present employment and, of equal significance, the effect of prior employment in order to rule out previous intoxication. Obviously there must be exposure to a toxic substance under unsatisfactory working conditions. Of prime importance, however, is knowledge of the mode of action or the effect of the toxic factor and this will be brought out briefly in the following discussion.

Heat Prostration and Heat Cramps

While the diagnosis in cases of exposure to high temperatures is relatively simple, knowledge of the effect of such exposure is needed both for prevention and treatment.

The mechanism of heat prostration probably occurs in the following way: The peripheral effect of heat is vasodilation, which is accompanied by a drop in blood pressure and an increased heart rate. When circulatory impairment exists there is a significantly decreased supply of oxygen to the tissues and muscle fatigue ensues. Since the magnitude of venous pressure depends largely upon the tonus of the muscle, the venous pressure drops and less blood is available for the right heart and the lungs. This sequence of events results in collapse.

Predisposing factors which make the worker more susceptible to the effects of environmental temperatures, therefore, are those associated with or contributing to faulty circulation, as old age, overweight, faulty diet, alcoholism, improper clothing and fatigue. And we observe that most cases occur in those with impaired circulation, there being adequate compensation when the circulatory system is in good order.

It follows that prevention of heat collapse in industry necessitates the selection of individuals whose circulatory system is in good condition and the institution of measures to maintain good circulatory tone. Preference should be given to individuals of normal weight and those not over forty-five years of age. Loose clothing should be worn and meals consumed before work should be light. Plenty of citrous fruits are recommended with the administration of 100 mgms. of vitamin C twice daily because of the apparently beneficial effect of the vitamin on the tone of the capillary wall. Plenty of drinking water and salt tablets are valuable in replenishing fluids and supplying electrolytes lost through sweat and other excretory channels.

---

*Presented before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

**Medical Director, E. I. du Pont de Nemours & Co.

As regards treatment the following suggestions are made: The patient upon feeling faint must seek a cool shady spot and lie down. He should never walk about. Clothing should be loosened and artificial respiration instituted, if necessary. Mixture of oxygen and carbon dioxide may be administered by inhalation. If the blood pressure is low strychnine, (1/20- 1/10 grain) may be given. The patient may then be given a lukewarm shower and plenty of water to drink provided salt is taken with the water.

Without a knowledge of the effect of the environment, therefore, we cannot adequately protect or treat the worker exposed to high temperatures.

Lead Intoxication

The multiple avenues of absorption are well known and will not be discussed. Prophylaxis is aimed at preventing or minimizing absorption or in substituting some other element. In its action lead affects many organ systems and this is important to remember in making a diagnosis. Evidences of lead poisoning are: Anorexia, metallic taste, cramps, constipation, sleeplessness, paralysis, wild dreams, pallor, lead line (this occurs in but 20% of cases) and tremor. There need not be increased blood pressure, but to the contrary it may be as low as 100/65. Stippled cells alone do not establish the diagnosis as there is no specific guide as to a significant number. From work done on 800 cases collected over a period of ten years one concludes that stippled cells can be used only as one sign of lead absorption. Lead in the urine up to or about .25 to .38 mgms. per liter or more, are significant of high exposures and indicative of impending acute intoxication.

Irritant Cases

Nitrous fumes illustrates the effect of an irritant action *per se* upon the lungs. The picture is apt to be misleading and hence needs to be stressed. Pulmonary signs are frequently not found in the early stages and any patient with a history of exposure should be put to bed and observed. Within a few hours râles appear, there is an increase in pulse rate and the patient is embarrassed for air. His chances for recovery are much greater if he has been at rest. Oxygen should be administered. There is usually present pulmonary edema due to the irritant action of the gas, but despite this condition forcing of fluids is usually beneficial, since it may help to increase excretion of toxic products. Because these patients are prone to develop a pneumonia they should be kept in bed and under observation for at least three weeks.

Among the highly toxic gases of industrial importance is hydrogen sulphide. Although the fact is not well recognized, it will cause instant death. The chronic effects are not significant.

Aniline and Dyestuffs

Aniline is absorbed through the skin and via the lungs. There are increased pulse and respiration, nausea and vomiting, cyanosis and unconsciousness. The patient presents the appearance of a terminal state of heart failure.

Treatment is rest and oxygen therapy. Death is not common unless the circulation is inadequate. Patients usually run a temperature for about five days after exposure, which is believed to be due to the breaking up of red cells by the combination of aniline with hemaglobin.

In the manufacture of dyestuffs the danger point is in the intermediate process of the manufacture, the completed products not being seriously poisonous. Two types of bladder tumors are caused by exposure thereto, simple papilloma and carcinoma of the bladder. Average time required for this end result is about eleven years. One of the first signs is blood in the urine. The final diagnosis of tumor is usually made by cystoscopy.

Aside from measures to minimize exposure to the compounds one should cystoscope periodically all workers who handle them and, furthermore, should cystoscope all applicants before accepting them for work under conditions where they will be exposed to these products. One applicant upon cystoscopy was found already to have fifteen bladder tumors. Had he been hired without necessary precautions it might have been difficult to deny claims for compensation. Here again knowledge of the mode of action of the substance is important.

Legg-Perthe Disease

With Particular Regard To Treatment*

MAURICE M. PIKE, M.D.,
Hartford, Conn.

The purpose of this short paper is to report in a preliminary manner certain observations on the treatment of ten cases of Legg-Perthe disease, the longest of which have been followed over a period of four and a half years, at the Newington Home for Crippled Children. Furthermore, through the kindness of Dr. J.H.T. Sweet, we have recently had access to a pathological specimen of this condition from a child of five who died of intercurrent disease. It is extremely unusual to obtain such specimens as the condition in itself is not fatal. We have but a single section to discuss at this time but hope to be able to study it in much greater detail.

As you know, this condition is one of osteochondritis juvenilis of the proximal femoral epiphysis, involving also the acetabular side of the joint in certain cases as well as the neck of the femur. The proximal epiphysis appears within the first year of life and unites with the shaft between approximately the 14th and 20th years. Between the ages of five and ten, apparently an age of very active development, one seems to find the greatest incidence of this condition. The clinical characteristics are those of a mild local inflammatory condition, i.e. pain, restricted motion, limp, rarely any general disturbance, with frequently the history of trauma.

The x-ray appearance is fairly characteristic and in most instances must be relied upon for diagnosis as any operative procedure, including biopsy is rarely indicated. There are variations in density; that is, areas of apparently increased density, as well as areas of rarefaction, with fragmentation. These changes are in the proximal femoral epiphysis, chiefly, but also may be seen in the acetabulum. There is also an apparent widening of the joint space and the neck of the femur is broadened, greatest at the head end. In spite of all these changes, if the bone does not become deformed by abnormal pressure or other stress during development, it will in certain cases ultimately become normal, which point will be dwelt on later in the discussion of treatment.

Platt of England (in a paper published in 1922) divides the course of the condition into three stages:

a. Stage of onset
b. Stage of activity
c. Stage of recovery

The limitations of these groups are sometimes difficult to define.

I should like to discuss, slightly further, the typical x-ray appearance.

First of the head: even with symptoms the x-ray may be essentially negative. There is usually flattening of the head with an irregular margin and also fragmentation. During the healing period this gradually becomes homogeneous again with a tendency to mushrooming or change in shape. These changes are slow and gradual over the growing period until one reaches the definite or final form.

Second: the neck of the femur which may have translucent, spongy areas with its characteristic widening.

Third: the appearance of the acetabulum indicates a change in contour suggesting a widening, associated with unossified cartilage. There are also changes of condensation and rarefaction along the acetabular margin.

The first case is that of a five year old boy who entered Hartford Hospital, less than a year ago, following an automobile accident. He appeared to have damage to the pelvis and x-rays revealed a typical Legg-Perthes disease of the left hip. According to the parents he had made no complaint regarding this hip and they had noticed no limp or apparent symptoms. On admission he

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

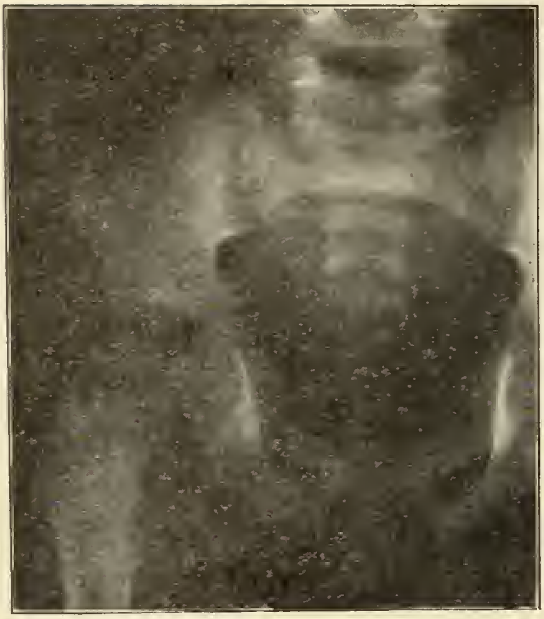


Figure 1

was in considerable shock and there was the suggestion of an intra-abdominal lesion or a left pneumothorax. He recovered, however, from his shock and respiratory embarrassment and was treated in a plaster spica for multiple fractures of the pelvis. At approximately nine weeks a brace was applied to the left hip and he began to try crutches. On the seventy-second day he again developed respiratory embarrassment and died with no elevation of temperature. Post mortem revealed a perforation of the diaphragm with the stomach and spleen shifted into left chest.

Figure 1 will show the x-ray of this patient. There are multiple fractures of the pelvis. The left femoral epiphyseal head is flattened and somewhat segmented. The femoral neck is thickened, foreshortened and the joint space is exaggerated.

Figure 2 shows a cross section of the gross specimen from within. The fragmentation of the epiphysis with areas of apparent necrosis are evident. Furthermore, the portion of the neck next to the epiphysis appears to show distinct changes suggestive of a degenerative process. It is to be noted that the ligamentum teres appears to be intact and of normal size.

Figure 3 and also Figure 4 are from a single microscopic specimen, the only one examined so far. These show considerable necrosis proximal to the epiphyseal line with considerable debris. No inflammatory reaction, however, is evident. There is some increased fibrosis and some round cell infiltration near the epiphyseal cartilage. The cartilage shows no actual change. Distal to the epiphyseal line, there is partial necrosis of bone. The picture is of degeneration without particular inflammatory infiltration. There are areas of apparently dead bone with the nuclei largely absent. The marrow spaces are devoid of blood cells. Other areas show fairly normal cellular bone development with regard to the cellular nuclei. Both of these features are shown in these slides.

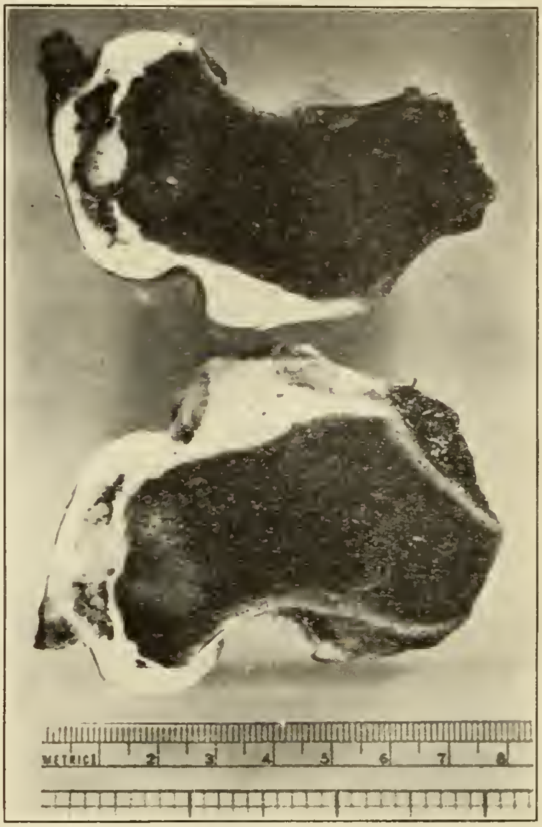


Figure 2

These changes correspond with the observations of others but it is our hope to study the specimen in greater detail.

There are, therefore, four types of changes noted pathologically:

1. Degeneration and proliferation of cartilage, bone and marrow.
2. Hemorrhage.
3. Necrosis.
4. Inflammatory changes.

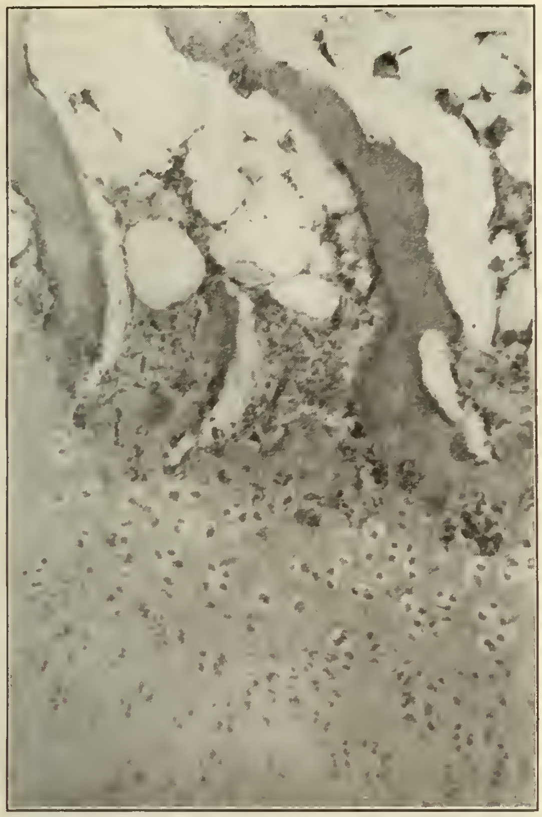


Figure 3

Treatment. It is our feeling that complete non-weight bearing is essential to allow the head of the femur to assume a natural and normal homogeneous state or that approaching normal. After observing the relatively incomplete co-operation of children of this age to remain non-weight bearing, even though they remain in bed, it seemed to point to the necessity of some type of apparatus. It must be noted that if the child is resting on the knees, weight is being borne by the hip and I believe that even this amount is undesirable. The principle is amply endorsed by other observers. Attention may be called to the cases of Dr. Murray S. Danforth, of Providence, which have been presented. A piece of apparatus suggested to us was the Wu splint. Such a splint is shown in Figure 5. This splint was proposed by Dr. Wu, while in Boston, originally as a means of maintaining congenital hip cases after manipulation.

For our use the extremes of abduction are not necessary but a splint that includes the lower torso and extends below the knee is an effective means of ensuring non-weight bearing for the hip.

It has been our plan of treatment on admission, if there are acute symptoms, or deformity, to apply Buck's extension until acute pain and muscle spasm have subsided and then apply the Wu splint which has been prepared in the meantime, usually a period of but two or three weeks. The splint is then worn night and day. Each day the splint is removed for the child to go to the physiotherapy department where active exercises, stretching and massage are given to maintain muscle tone and increase joint function. This type of treatment can, of course, be carried out best in an institution where teaching facilities and nursing care are available. I, personally, do not believe that ambulatory splints are efficient in preventing weight bearing and I also feel that these relatively small amounts of weight bearing are detrimental to the satisfactory restoration of the head and joint space.

The remaining figures demonstrate the first and last x-rays of some of our ten patients. It has been our habit to x-ray cases at six months' intervals.

Case 2 W. D. — Figure 6 shows an osteochondritis of the left hip as of February 1935.

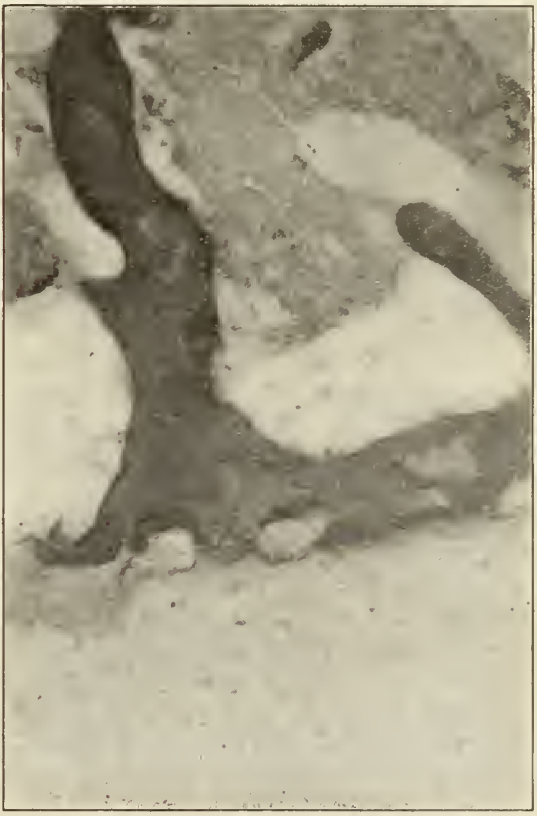


Figure 4

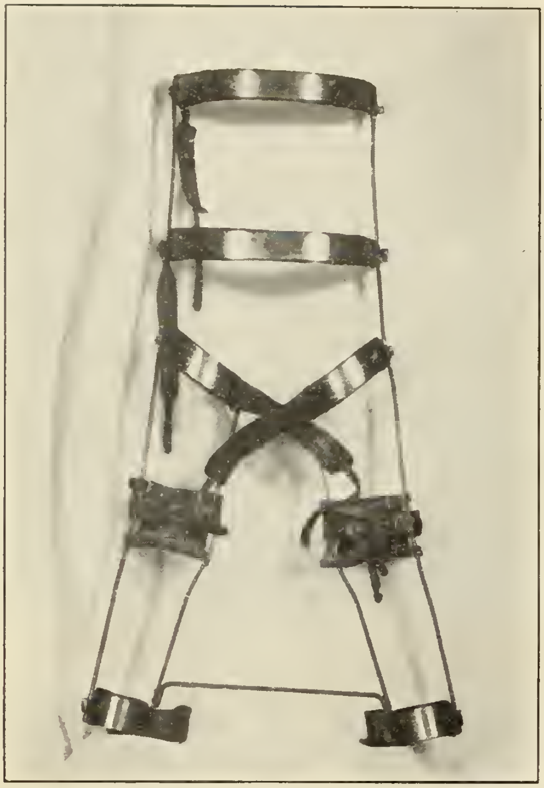


Figure 5

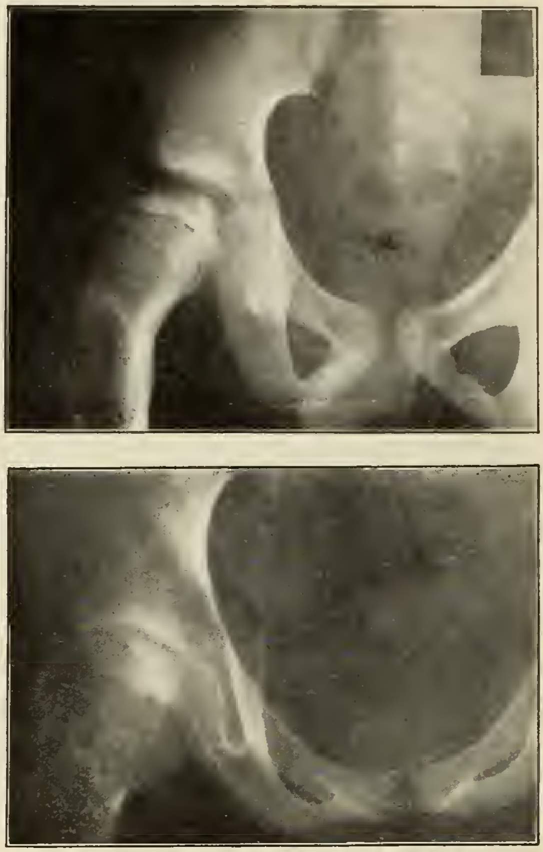


Figure 6

This shows the head flattened, somewhat rarefied and elongated in its transverse diameter, with associated increase in width of the adjacent femoral neck. The joint space is definitely exaggerated with the acetabulum tending to be shallow. This boy was ten years old, at this time, with the onset one year previously of pain and limp. Below, shows the present x-ray appearance, May 1939. His legs are equal in length. Flexion of the left hip is present to 30 degrees beyond a right angle. Rotation is normal. Abduction and adduction are very slightly limited. As the x-ray appearance has not changed over that of six months ago, we are now allowing him to begin to get up. The bone is more homogeneous in appearance and smoother. There does remain widening and foreshortening of the femoral neck but with no clinical evidence of shortening. There is also improvement in the appearance of the acetabulum.

Case 3 J.S. — Figure 7 shows the x-ray appearance of this boy, age eight, on April 27, 1935. His complaint was of pain in the right hip and limp for five months. There is flattening and segmentation of the epiphyseal head on the right with associated broadening of the femoral neck. The acetabulum is shallow.

The lower view, as of February 1939, shows the epiphyseal head largely regenerated, although it remains flattened and elongated. The joint surface is smooth. There is much less rarefaction. The acetabulum appears elongated as a compensatory change. Shortly after this x-ray, he began to be ambulatory. This enlarged head is easily palpable and it will be interesting to note the effect of weight bearing. There is no limitation of flexion or rotation. Abduction is slightly limited on the right. Legs are equal in length.

Case 4 J.W. — Figure 8 represents one of our more satisfactory patients, from the point of view of end result. The x-ray in 1936, when the patient was nine years old, shows moderate flattening of the left femoral epiphyseal head, areas of rarefaction and some bone intensification The femoral neck is foreshortened and broadened. The acetabulum appears essentially normal. He complained of a limp only on admission. He remained in his Wu splint nearly three years, to January 1939. Below, taken Jan-

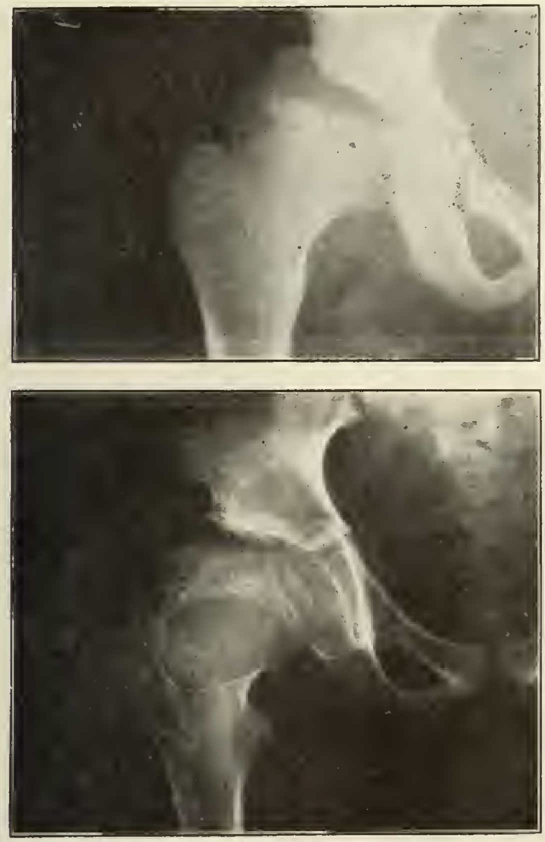


Figure 7

uary 16, 1939 reveals great improvement and no very gross change for approximately a year. There is one small area of rarefaction remaining. The neck remains broadened and the joint space widened. Clinically, he is walking now with crutches, bearing some weight. He has no limitation of rotation or abduction and legs are equal in length. There has been some difficulty in regaining his balance in the upright position after the long period of recumbency but that has now cleared. His complaint, on admission, was limp only for a period of three months.

Case 5 M. W. — Figure 9. This boy was admitted 1936, at the age of twelve, with a history of pain in the left hip of rather uncertain duration. This x-ray, at that time, shows osteochondritic involvement of both hips, our only bilateral case. The right epiphysis appears to show more absorption with increased density of both acetabula. The necks of the femora are broadened. Both joint spaces are good. It appears that the changes are slightly more marked on the right. The boy is still recumbent. Figure 10 taken in January 1939, over two years later, shows great improvement. The right still shows some fragmentation although the shape of the right head appears better than the left. The calcification is more homogeneous. Clinically, the legs are equal in length, flexion is present to 30 degrees beyond a right angle. On the right, abduction appears essentially normal but it is restricted on the left.

The remaining cases are now summarized without reproduction of the figures which are similar to those already presented.

Case 6 J. J.—This is a boy, age five, who was first x-rayed in January 1934. His recumbency dates from the summer of 1935. I have never felt satisfied with the diagnosis in this instance but the x-ray department has consistently classified it as an osteochondritis. The deformity is extreme. He gives a history of an apparent infection at the age of seven months which I believe may have been a low grade suppurative process. Recumbency for two years in the Wu splint made little apparent difference and because of the instability, a shelf operation was

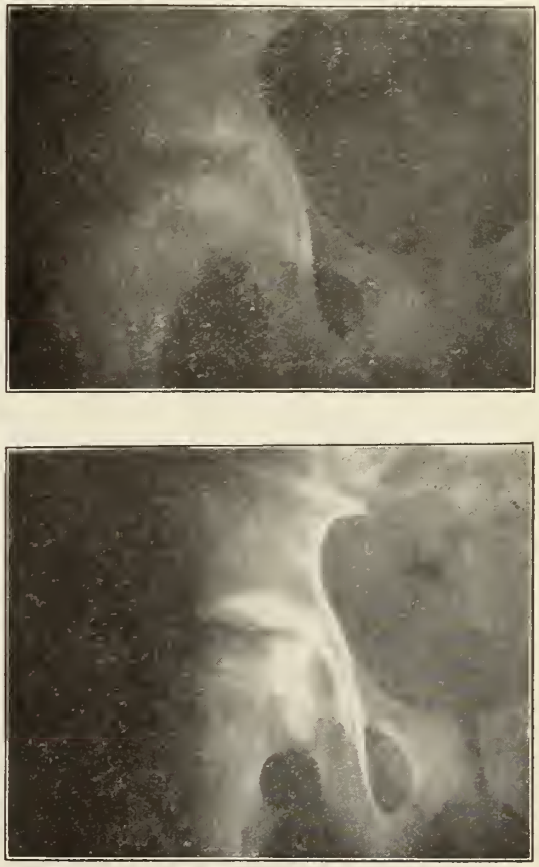


Figure 8

done on April 7, 1938. At admission, he had one inch of shortening and he still has that amount. At the end of one year, following the shelf, he is walking with a raised shoe. Although he appears to have some separation of the shelf, the hip is stable. There is no piston mobility and he has no pain. I do not feel that this is a true Legg-Perthe syndrome but I have included the record because of the apparent osteochondritic involvement. He has some limitation of motion in all directions and some lateral sway when walking.

Case 7 W. M. — This boy entered the Newington Home about three years ago, at age nine, with the history of lameness for ten months. X-ray, in July 1936, shows marked flattening and segmentation of the right femoral epiphyseal head. The neck is widened with a flat and elongated acetabulum. He had a flexion and adduction deformity which was corrected by Buck' extension in one week. He has now been in his Wu splint nearly three years. X-rays over this period, at six month intervals, have shown some gradual improvement. The last x-ray, taken on February 23, 1939, shows the head more rounded and the rarefaction less marked. Clinically, his legs are equal in length and there is extremely slight limitation of external rotation and abduction on the right. He is still recumbent in his Wu splint.

Case 8 L. J. C. — This child has been with us for just two years. The first x-ray was taken May 25, 1937, and shows slight flattening of the left proximal femoral epiphysis with widening of the joint space. There is slight rarefaction and some increased density with also some rarefaction on the neck side of the epiphyseal line. This is the only girl in our series and she was eight on admission with the complaint of pain in the left hip and a limp. She sought medical advice within two weeks of onset, and x-ray examination at that time revealed the osteochondritis. Those films are not available. The most recent films indicate some slow but gradual improvement. There are still areas of rarefaction and deformity. She is still recumbent with legs equal in length. The extreme of flexion is the only limitation of motion of the left hip at this time.

Case 9 W. E. — This patient, at the age of eight, was admitted on the same date as the preceding patient, two years ago. He complained of a left leg limp of one year. No pain. X-ray, on May 18, 1937, shows a honeycombed appearance with rarefaction in the foreshortened, flattened proximal femoral epiphysis on the left. The joint space is exaggerated with broadening of the neck and a coxa vara tendency. He has had two years of recumbency. There is now some remaining rarefaction with disappearance of the increased density giving the head a more homogeneous appearance. The outline of the head has become sharper and the joint space appears satisfactory. He has no evidence of shortening and no restriction of motion in either hip. He is to remain recumbent for further x-ray observation.

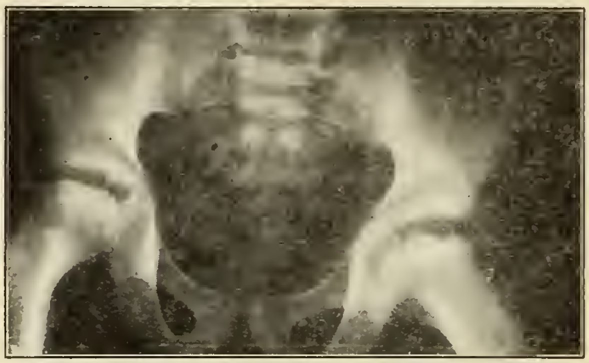


Figure 9

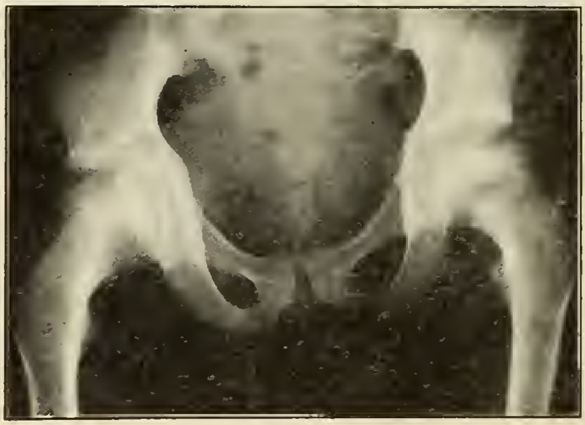


Figure 10

Case 10 J. G. — This boy of eight was admitted, slightly less than two years ago, with a limp of eight months duration in the left hip. A spica had been applied elsewhere for ten weeks. He had marked restriction of motion. X-rays showed fragmentation with rarefaction and condensation of the left proximal femoral epiphyseal head with flattening. There are also changes in the neck with the joint space widened.

After six months of recumbency, there was increased flattening and rarefaction by x-ray but by the end of a year distinct improvement began. Now we see a smoother articular surface with definitely less rarefaction evident, approximately one and one half years after beginning treatment. Legs are equal in length. There is some limitation of flexion and abduction. He is, of course, still recumbent.

Case 11 J. L. — This boy of five was admitted less than a year ago, with pain in the right hip of five months duration. X-ray, taken elsewhere shows considerable flattening and irregularity of the right femoral epiphyseal head with segmentation. The joint space seems exaggerated. X-ray, taken after eight months of recumbency shows a definite progression of the process with increased fragmentation as in the preceding case. Further observation is, of course, necessary but this fact of progression, in spite of non-weight bearing, makes me believe all the more strongly in the principle of complete non-weight bearing during this difficult period of adjustment in order to allow satisfactory improvement and a minimum of deformity. Clinically, he has no pain, legs are equal in length and flexion and abduction are but slightly limited in the extremes of motion on the right.

Summary

In summarizing, I should like to state that these patients all have negative Wassermann. One case had a questionable Wassermann on admission but several repeats have been entirely negative. Eight cases have negative Mantoux tests (0.1 cc. of 1/1000 dilution). Two have not been tested. There is a history of definite trauma in but four cases — 40%.

Of the ten cases, two have been observed more than four years and are now ambulatory. Four others have been observed three years and two of these are ambulatory, one of them being the patient of uncertain diagnosis. Three others have been treated two years and one less than a year and are still recumbent.

There are six cases with left hip involvement, three with right and but one with both hips involved. Also there is but one female in the entire group — 10%. Five entered with the complaint of a limp only, and five both pain and limp.

The ages, on admission, were from five to twelve with the average eight and two-tenths years. Further observation will be interesting.

In closing, I shall give but one reference — "Localized Rarefying Conditions of Bone" by E.S.J. King, of Melbourne, Australia, who offers a bibliography of 426 references on Legg-Perthe disease or osteochondritis of the upper epiphysis of the femur.

I should like to take this opportunity to thank my associate at the Newington Home, Dr. Frank S. Jones, who has followed these cases with me with interest.

COURSE IN OBSTETRICS AND GYNECOLOGY AT YALE

The Department of Obstetrics and Gynecology of the Yale University School of Medicine announces a Postgraduate Course of six conferences in Obstetrics and Gynecology to be held weekly beginning Friday, February 16, 1940. As in the course of the previous year, these conferences will stress the practical points in these fields which will be of interest to the general practitioner. The conferences will be informal and will afford those who attend an opportunity to discuss their own particular problems. Owing to physical facilities the course will be limited and members of the Connecticut State Medical Society who wish to attend should apply to the Department of Obstetrics and Gynecology before February 1st. The fee for the course is ten dollars.

EXHIBITION OF CUSHING MEMORABILIA

The Yale University Library announces an exhibition of memorabilia relating to the life and works of Dr. Harvey Cushing to be on view at the Library until January 25th.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

The Present Trend in The Treatment of Progressive Deafness*

NORTON CANFIELD, M.D.,†
New Haven, Conn.

Ever since Passow[1], in 1897, demonstrated that an artificial fistula in the otic capsule was followed by marked improvement in hearing, the fire of enthusiasm for a significant surgical method of treating deafness has smoldered with occasional recrudescence. Opposition was almost universal and discouragement came from such authorities as Politzer[2], Moure[3], Siebenman[4], Botey[5], and Denker[6]. A few years later Barany[7] suggested a fistula into the posterior vertical canal. This was accomplished but results persisted only a few days. Jenkins[8] in 1913 opened horizontal canals in two patients. However, soon thereafter one patient lost all hearing in the operated ear and the other lost so much that the method was abandoned.

An evaluation of the various methods of treating chronic progressive deafness without aural suppuration leaves a great deal to be desired. During the past twenty years great strides have been made in the anatomy and physiology of the ear. Correlation between auditory acuity and actual lesions of the cochlea and nerve paths has clarified much of our thinking about interpretive audiometry. The old criteria for locating the lesion have been revised and no longer can we be dogmatic about designating a nerve deafness if high tones are effected and an obstructive deafness if low tones are diminished. Bone conduction has been found to be an extremely complicated phenomenon involving physical conceptions too intricate for any but those mathematically trained to understand.

Along with the intense interest in the fundamentals of hearing, the clinical phase has been developed and accumulated knowledge has been applied to patients. With the tremendous advance in radio and all phases of sound transmition and amplification has come improvement in the electric hearing aids. Their efficiency has been greatly increased and now many more people are satisfactorily helped by means of these instruments. Some otologists consider that they are the best means of improving hearing, but many patients are still not satisfied because of the extraneous noises produced and the excessive amplification of noises other than the voice. An important defect in the electric hearing aid is that it lacks the ability of the normal ear to maintain automatically the normal proportion of sound with increasing distance. Fowler[9] has recently enumerated some of the other difficulties with the electric aids as well as the problem involved in prescribing the various types of instruments.

With all of this notable effort to help the deaf, a few otologists have maintained hope and courage for a solution of the problem in another manner. The histologic work has shown that in many ears the cochlear mechanism remains intact and only because sound energy does not reach the cochlea to be transformed into electric energy has the ear partially lost its microphonic ability. In otosclerosis and other diseases which fix the ossicular chain, the ear has a diminished efficiency requiring thereby louder outside sounds to produce sufficient electrical potential in the neural mechanism to stimulate the auditory brain centers.

For the past twenty years knowing that an otic capsule fistula does improve hearing, Gunnar Holmgren[10-a and b] has gradually evolved a method of operating which produces a satisfactory fistula of varying permanence. His first efforts were directed toward making the opening in the region of the promontory. This involved such careful handling of the membranous labyrinth that the method was soon abandoned. He now makes the fistula in the external semicircular canal. In the early 1920s Sourdrille[11] while visiting Holmgren was impressed with the possibilities and took up the work with avidity at Nantes, France. Between two and three hundred cases have now been operated upon by various methods. A recent report from Lempert[12] in this Country has been encouraging.

---

*Presented to the Otolaryngologic Section of the Connecticut State Medical Society, September 29, 1938.

†From the Department of Surgery, Yale University School of Medicine, New Haven, Conn.

The Type of Deafness Which Responds to Operation.

The selection of cases to submit to this type of operation is not difficult. Integrity of the cochlea and the neural mechanism which transits sound from the internal ear to cerebral centers is essential. When bone conduction is normal or increased for the critical frequencies of 256 to 2048 cycles per second, the neural mechanism can transmit the human voice. Although bone conduction testing is still not very accurate, yet if it is not markedly decreased, the cochlea is functioning in a manner to permit good hearing. If bone conduction is found to be decreased, the neural mechanism may be intact, but at present this cannot be determined clinically.

To satisfy man's normal desire for contact with the environment, hearing by air conduction must be within the conversational range. Below this level important sounds and especially the human voice are not heard loud enough for proper interpretation. If then, we select those whose hearing by air conduction is decreased, but whose bone conduction is normal or not markedly decreased, we can include them in the group whose air conduction will be improved with a labyrinthine fistula. Age, occupation, general physical condition and most important, the psychological reaction of the patients must also be considered. The presbyacusis of advancing age may blur a clear conception of the type of hearing loss. Some people work in an environment where better hearing is not necessary to continue employment. Those who have obvious debilitating diseases as diabetes, nephritis, tuberculosis, are not good risks.

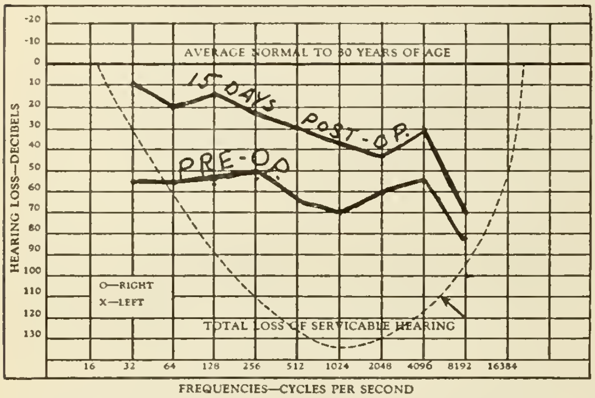
Psychologically the deafened person is complex. Many do not wish to hear again and take their infirmity as an adequate excuse for their mental aberation. Deafness for many constitutes an escape from the realities of life. These people do not wish a cure. Young people below the age of forty, however, still have the desire of normal social contact and usually seek advice and submit to anything which offers a ray of hope. With these you are all familiar and how much we have dreaded the advice which has been necessary to these unfortunate people!

The etiology of this type of deafness varies but it is frequently due to the pathologic process known as otosclerosis. The same type of hearing loss may be caused by other processes in the middle ear which cause a fixation of the stapes footplate. Since tinnitus is the other important symptom caused by otosclerosis an etiologic diagnosis is not necessary and only the type of deafness need be determined to consider operation.

The term "otosclerosis" should be used only to designate a pathologic entity and not as a clinical diagnosis. It is a disease of bone occurring in and around the otic capsule and incidentally involves the hearing mechanism. The disease progresses to involve the ligament around the footplate of the stapes. This fixes the ossicular chain, and interferes with the transmission of air borne sound to the cochlea. Sometimes, however, the otosclerotic process invades the bone of the modiolus and the osseous spiral lamina thereby effecting the cochlear nerve or other portions of the neural mechanism. When this occurs sound perception is on the wane, bone conduction is decreased and operation is of little or no value.

I have recently had an opportunity to study the method a little more carefully. Professor Holmgren permitted me to visit and work in his laboratory during this past winter. He was then working on a method of producing an artificial fistula through the external semi-circular canal. He had operated on more than one hundred patients without a fatality. Many had immediate marked improvement in hearing and some had maintained it for a considerable time. One patient on whom he had operated eight years ago had kept enough improvement to continue her position as a musician without interruption.

Holmgren's[10-c and d] method consists in producing the fistula in the external semicircular canal at its accessible portion in the floor of the aditus. This is done by the post-auricular, trans-mastoid approach. The hole must be covered with a membrane and the struggle has been to have it protected with some type of tissue which will not permit or encourage bone proliferation to fill in the defect. The best method for doing this has not yet been determined. I shall present an audiogram of one of Holmgren's patients, the second stage of whose operation I witnessed.



The preoperative hearing loss averaged about 60 decibels for the critical frequencies. Six days after the operation the effect was not satisfactory, Fifteen days post-operative the hearing improvement was as indicated with an average loss of about 31 decibels. If we consider now that this patient, age 35, may not have had an original hearing of exactly normal, we can see that the improvement following operation is of great significance. How can this improvement be maintained? It is now considered that this depends upon the patency of the fistula and arrest of the otosclerotic process. The solution of this phase of the problem is now the important factor in this type of therapy.

While in Stockholm, Holmgren had me work on his experimental program. We studied the effect of various foreign bodies on bone proliferation. It is well known that cholesteatomas produce and maintain labyrinthine fistulas for many years. The process by which this is accomplished has been carefully studied, but since it is always associated with infection with pyogenic bacteria, it has not been considered wise to infect the cavities at the time of operation. In fact, accidental infection has been the great deterring influence for the development of this procedure during recent years. We implanted a number of foreign bodies but by this method we were unsuccessful in discouraging the growth of the bone. Most of these substances seemed to stimulate bone activity as indicated by careful microscopic examination. Some other biologic principles must be used. Electrolysis of bone in the presence of certain metals has been found to be the cause for non-union of fractures of the long bones in which metal plates had been used for fixation. This might be of service for our problem, but we have not established its efficacy so far. Knowing the effect on other bones of x-radiation, this was considered and tried. A radium preparation was made and placed in the newly prepared fistula of the monkey. After seven days it was removed and the animal allowed to live for four weeks. Temporal bone sections were then made by Professor Nager of Zurich and in the region of the fistula not only was there no bone regeneration, but the surrounding bone appeared to be undergoing devitalization. This was precisely the effect which we had hoped for and probably represents the first time such a phenomenon has been observed.

How long improvement will be maintained cannot be predicted in any individual case. The biology of bone is still a matter requiring far better knowledge of its intricate processes. To produce a fistula is not difficult, but to maintain it is a matter of more specific attention to the fundamental nature of the otic capsule bone.

Two other surgical approaches to the problem of deafness are now in the process of development. Walter Hughson[13] has found by experimental means that immobilization of the round window membrane in experimental animals markedly increases the potential in the action current from the auditory nerve in carefully controlled experiments. With this as a stimulus for clinical application of this principle, he is now making fascial grafts in the round window of deaf patients through the tympanic membrane. A recent report including his audiograms has shown improvement in all of his twenty-one cases. The improvement seems to be progressive and this work is being watched with a great deal of interest. Nothing but praise can be voiced for the exceedingly careful manner in which he works and I can assure you that some of his patients believe that they have far better improvement than is indicated by the audiograms.

Wittmack[14] has proposed and is doing an operation which he considers changes the blood supply to the otic capsule. This he does by elevating the dura around the petrous apex in the hope of obliterating hypothetical venous stasis. His operation is based upon experimental evidence derived from a chicken experiment in which he claims to have produced the pathologic changes identical with otosclerosis. I visited his clinic in Hamburg but was quite unconvinced in the short time I had at my disposal. Other workers have failed to confirm his chicken experiment and although I saw none of his patients, the method of hearing testing in his clinic is very difficult to evaluate. Wittmack does not claim any improvement in hearing, but rather a cessation of the progress of the deafness.

The improvement of the electric hearing aid and the surgical attack constitutes by no means the only method by which progressive deafness is treated. However, most of the other types of therapy have been exceedingly disappointing. The injection of tyroxin into the tympanic cavity as advocated by the late Sir Albert Gray[15] has not proved to be of any value. The various methods of attacking this disease from the standpoint of metabolism and endocrine therapy have not produced anything of significance. The tremendous value of the work for the education of the hard of hearing person has continued to be of great value under the direction of our own colleague, Doctor Frederick N. Sperry.

The picture of chronic deafness is not quite as dark as it was ten years ago. We can now offer hope which a few years ago was quite impossible. At least many young people can now be encouraged by telling them that the present trend indicates that real help will be available in the near future.

In his complete report, including a resume of sixty-eight cases, Holmgren concludes that "Justification of surgical treatment is dependent upon the permanent results obtainable. Undoubtedly good and even excellent immediate results are now possible; the duration of these results has been increasing for decades and it appears probable that within a relatively short period such unmistakable and lasting results will be possible that, after all, a question of the risk involved will come to be considered as relatively insignificant when compared with the results."

BIBLIOGRAPHY

1. Passow: In Discussion of Paper by Panse, R. Verbandl, d. deutsch otol. Gesellsch, 6:141, 1897.

2. Politzer, A.: "Ueber das anatomische Verhalten der Stapesplatte bei der Otosklerose." Verbandl, d. deutsch. Otol. Gesellsch., p112., 1908.

3. Moure, E.J.: "Traitement chirurgical de l'otite moyenne chronique; formes seche, adhesive et sclereuse." Rev. hebd. de laryngol., 18:641, 1898.

4. Siebenmann, F.: "Traitement chirurgical de la sclérose otique." Tr. Internat. Cong. Med., Sect. Otol. p. 170, 1900.

5. Botey, R.: Traitement chirurgical de la sclérose otique." Tr. Internat. Cong. Med., Sect. Otol. p. 177, 1900.

6. Denker, A.: Die Otosklerose Wiesbaden. (Ohrenheilkunde der Gegenwart, No. 4). 1904.

7. Bárány, R.: Quoted by Fremel, F. "Demonstration eines wegen Otosklerose von 8 Jahren operierten Patienten." Monatsschr. f. Ohrenb., 56-552, 1922.

8. Jenkins, C.J.: "Otosclerosis." Tr. Internat. Cong. Med., Sect. 16 (Otol.) pt. 2:609.1913,

9. Fowler, E.P.: "Use of Threshold and of Louder Sounds in Clinical Diagnosis and the Prescribing of Hearing Aids." Trans. American Otology Soc. 1938.

10. Holmgren, G. (a): "Operations on the Temporal Bone Carried out with the Help of the Lens and Microscope." Acta. Otolaryng., Vol. IV, No. 4, p. 383, 1922.

(b): "Some Experiences with the Surgery of Otosclerosis." Acta. Otolaryng. Vol. V, No. 4, p. 460, 1923.

(c): "The Surgery of Otosclerosis." Ann. Otol., Rhin., and Laryng. Vol. 46, p.3, March 1937.

(d): "The Surgery of Otosclerosis." Nelson's Loose Leaf Surgery, 1938.

11. Sourdille, M.: "New Surgery in Otosclerosis." Laryngoscope, Vol. 46, p. 853, Dec. 1937.

12. Lempert, J.: "Improvement of Hearing in Cases of Otosclerosis." Arch. Otolaryng., Vol. 28, pp. 42-97, July 1938.

13. Hughson, W.: "Rationale, Technic, Case Reports and Observations of Grafts in the Round Window." Transactions of the American Otological Soc. 1938.

14. Wittmaack, K.: "Operative Behandlung der Otosclerose mit Duraluftung." Klin. Wchnschr., Vol. 12, Page 658, 1933.

15. Gray, A.A.: "The Treatment of Otosclerotic and Similar Types of Deafness by the Local Application of Thyroxine." Laryngoscope, Vol. 45, p. 741, 1935.

The PROFESSIONAL EQUIPMENT Co.

RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.

TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

Treatment Procedures for Cancer of the Uterus Advised by The Connecticut Tumor Clinics*

JAMES RAGLAN MILLER, M.D.,†
Hartford, Conn.

In the near future there will be distributed to every physician in Connecticut a pamphlet on cancer. It is hoped that practicing physicians will find the information of material assistance in the early recognition and proper care of malignant conditions.

The Connecticut Association of Tumor Clinics has gone one step further and has distributed to all its member clinics outlines of treatment which have been recommended. These programs have been worked out by sub-committees and have been adopted by representatives of the various clinics. It is the suggested program for treatment of carcinoma of the uterus which we are to discuss today.

In suggesting these programs there is no thought of compulsion but rather a plea is made for the widespread cooperation on the part of all of our physicians in the attack on these unsolved problems by the method of pooling our experience. If this be done we can assemble in a few years a number of cases treated according to definite procedures much larger than any single clinic could possibly command. In cancer work we are handicapped by having to wait three to five years before we can decide which of two methods is the better and such a cooperative effort is highly desirable.

Physicians of the state are being asked to adopt these treatment programs for their own cases, following the outline as closely as possible but feeling entirely free to deviate therefrom as the individual case may require. Such changes, however, should be most carefully considered and the reasons for making the changes should be recorded. It is contemplated that the recommended program itself may be altered from time to time but as far as possible these alterations will be made on the first of January of each year. The advantages of this procedure in a field where we do not yet know the best possible methods is at once obvious and the profession of this state has a rare opportunity to make a real contribution in the evaluation of various methods of treatment.

This is not the place nor is there time to discuss the details of dosage, etc. It is my purpose rather to discuss some of the reasons which have lead to various suggestions in the program. Most of the details have actually been routine procedures in many of the clinics of the state.

Uniform terminology is essential. The "STAGE" of the disease is designated as: 1, the earliest lesion confined entirely to the organ itself; 3, the most extensive involvement with or without metastasis; and, 2, a stage intermediary — more detailed discussions for staging are given in the outline. Evidence is accumulating that the stage at which treatment is begun is, for most carcinomas, far more important than is the histological grading of the tumor itself. We must, however, have microscopic evidence of each tumor, not only for proof that we have a malignant condition, but also that we may make use of the knowledge that, in general, Grade 1 tumors are more resistent to radiation, are more often slow-growing and metastasize less frequently than do the immature Grades 3 and 4.

There should always be a record as to whether the treatment was given with reasonable expectation of cure or whether it was merely for palliation. Again, if operation is not possible it should be stated whether this was because of the extent of the growth or only because of the patient's general condition.

Modern carcinoma therapy such as that outlined, whether it calls for operation, radiation or both, will tax severely the physical and mental resources of the patient. Some member of the family should understand this. Great care should be taken to fortify the patient by diet, transfusions and, in fact, by all of the resources of modern medicine so that complications may be reduced to a minimum or may even be avoided altogether. The cystoscope and proctoscope are invaluable instruments in the treatment program, for the neighboring organs, though they may not be involved in the tumor growth, seldom escape more or less serious alterations attendant upon radical operative or radiation treatment of the uterus.

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

†Obstetrician and gynecologist, Hartford Hospital.

In carcinoma of the cervix, unless the growth is very early, x-ray therapy is given first for three reasons: 1, bleeding is controlled; 2, dangerous infection clears up before the intrauterine radiation is given; and 3, the growth itself usually shrinks so much that the outer edges are brought closer to the radium when it is applied. In early cases it makes less difference which sequence is followed.

Radium is advised to be given two to four weeks after the x-radiation course of treatments has ended, at a time when the advantages just spoken of have been obtained. The fundus as well as the cervical canal must be treated and this usually requires an anesthetic and a stay of not more than one or two days in the hospital. One week later the vaginal portion of the cervix is exposed to surface radiation for which no anesthetic is required and it is often unnecessary for the patient to spend a night in the hospital. It is sometimes necessary to shorten the interval between the x-ray and the radium treatments if there is marked shrinkage of the upper vagina, for this might interfere with the proper application of radium and lead more easily to damage of the rectum and bladder.

Follow-up examinations should be made if possible by the physician who gives the treatment and who has, from previous pelvic examinations, the ability to estimate changes and evaluate symptoms. Injuries of bladder and rectum and the occasional occurrence of pyometra should be detected early and brought under immediate treatment.

The family physician should familiarize himself with the general outline of this treatment program so that he may cooperate in obtaining for his patient adequate treatment. It is not wise, however, for him to inform the patient in advance of all of the details, some of which may have to be altered as treatment progresses. Patients become easily alarmed at such changes and 'back-seat driving' is quite out of place in cancer therapy.

While some clinics still prefer to operate whereever possible for carcinoma of the cervix, it is to be hoped the accurate records and follow-up notes from such clinics will be able to present their material so that we may obtain a decisive appraisal of the relative merits of operation versus radiation. It is apparent that these clinics are not yet convinced that radiation without operation is better therapy and where the majority of clinics appear to hold different views, it would seem that the Association of Tumor Clinics and our profession throughout the state should learn as quickly as possible which of the two procedures should be recommended.

In carcinoma of the fundus there is general agreement that radical removal of the uterus, tubes and ovaries is advisable. It is questionable, however, whether the most malignant, most radiosensitive Grade 4 cases are not actually injured by operation since they metastasize so readily. Further experience is needed to prove definitely the superiority of radiation alone in this small group. For Grade 1, the so-called adenoma malignum, there is considerable doubt as to whether it is really malignant or not. Certainly experience already shows that radiation is not necessary in this group.

There may be some difficulty in designating the stage of the disease in carcinoma of the fundus, especially if operation is not done but it is thought advisable to make the attempt and the three stages suggested appear to be very significant in the evaluation of our treatment programs. In obtaining a specimen by curettage, vigorous scraping of the uterus must be avoided. In suggesting a delay of one week after curettage before inserting radium into the uterus in cases where radium was not available at the first sitting, it is suggested on grounds which are perhaps theoretical. Some authors report that this can be done with impunity at any time but others have noted that occasionally infections arise and it would seem wiser to wait one week if possible to avoid this danger.

Adenocarcinoma of the fundus which has extended into the cervix is recommended for treatment according to the cervix carcinoma program. Experience, however, is needed on this point. There seems to be little doubt that epidermoid carcinomas of the cervix which do not involve the portio vaginalis and which appear clinically like fundus carcinomas should be treated according to the cervix program.

As the profession and the public become more and more cancer minded, we shall get an increasingly high proportion of early cases. Our results with these early cases is not yet as good as it might be because presentday knowledge and available skill are not brought to bear from start to finish. We have come to realize that the treatment of cancer of the uterus is not a one man job and there should be brought into consultation as early as possible, either in the individual cases or by the adoption of such programs as these, all of the physicians who may be called upon to accept some of the responsibility.

The presentation of these programs of treatment is made not only to facilitate the early recognition of carcinoma but to expedite the early application of a well-organized attack and to make it possible for us to see for ourselves which improvements need to be made.

PROGRAM SUGGESTED BY TUMOR CLINICS OF CONNECTICUT FOR TREATMENT OF CANCER OF THE CERVIX, BODY OF THE UTERUS AND BREAST

Cancer of the Cervix

1. HISTOLOGY — designate histological grading in four groups from (1) the most mature to (4) the most immature type of cell.

2. DIAGNOSIS in all cases should be made by biopsy before starting treatment or immediately thereafter.

3. STAGE OF THE DISEASE — Designate stage to which disease has progressed.

Stage 1—for the early case where the lesion is confined entirely to the cervix.

Stage 2—the lesion has spread beyond the cervix but not as far as in Stage 3.

Stage 3—massive infiltration of both parametria extending to the walls of the pelvis, carcinoma involving the bladder or rectum, infiltrating the whole vagina, or remote metastases.

Make separate classification for "carcinoma of the cervical stump, previous hysterectomy" and for "secondary cases" (those which have had part of their treatment elsewhere).

Bear in mind that classification of the stage of the disease may be ten per cent, or even more, in error, and descriptive notes should be complete enough for anyone reviewing the case to make a reasonably accurate classification.

4. The patient's GENERAL CONDITION should be designated as "Good," "Fair," or "Poor."

5. Before embarking on the TREATMENT PROGRAM, an understanding should be arrived at between all physicians who are later to participate in such treatment.

6. Make sure that enough data is on the record concerning the patient's nearest relatives and family physician so that FOLLOW-UP will not fail.

7. Provide for the best possible MEDICAL SUPERVISION of the patient during treatment.

8. Obtain CYSTOSCOPIC STUDY of the urinary tract early in the course of treatment and examine the rectum with the PROCTOSCOPE.

9. WEEKLY VAGINAL EXAMINATION should be made during x-ray treatment to note shrinkage of the vagina which might interfere with later radium application.

10. The following PLAN OF TREATMENT is suggested with the explicit understanding that any physician may deviate from the plan when that is necessary in a particular patient. Reasons for deviation from the suggested plan should be noted specifically.

The plan of treatment is to give divided adequate x-radiation through four portals; four weeks after the end of the x-radiation, adequate intra-uterine radium application, and within one week thereafter application of radium against the cervix in the vagina. If excessive shrinkage of the vagina is noted during x-radiation, interrupt treatment, and give intra-uterine and vaginal radium applications. Then complete the x-radiation. In the treatment of advanced cancer of the cervix x-rays should be given first, while in the early stages either radium or x-rays may be used first.

Cancer of the Body of the Uterus

CLASSIFICATION

HISTOLOGY—Grade 1-4, from (1) the most mature to (4) the most immature type. Classify as adenocanthoma in addition to grading where there is squamous cell metaplasia. The STAGE of the disease is to be noted, using the classification "1" for the most early or localized, to "3" for the most advanced or extensive.

STAGE I includes cases where the physician feels that the cancer is presumably confined to the endometrium.

STAGE II, the duration of symptoms is longer, and clinical examination indicates that the disease is already extended beyond the uterus and that there is considerable doubt of being able, by operation, to eradicate all cancer tissue.

STAGE III, advanced carcinoma with fixation, wide local extension or distant metastases.

Suggested Plan of Treatment

1. D. & C. with FROZEN SECTION (histologic grading should not be made on frozen section).
2. Immediate insertion of RADIUM treating the entire fundus and cervix with an adequate dosage appropriately filtered.
3. Six weeks after radium application, PANHYSTERECTOMY. Frequent deviations from this suggested routine may be necessary.

1. If radium is not available at the time of curettage. In this case x-ray treatments may be given while waiting for one week to elapse before again entering the uterine cavity with radium, and proceed as above.
2. When a diagnosis of Grade 1 (adenoma malignum) is made, neither x-ray nor radium need be given, and panhysterectomy is done, if possible, in ten days.

When a patient with carcinoma of the fundus is classified as INOPERABLE, the procedure suggested is as follows:

1. If inoperable due to POOR GENERAL CONDITION, give radium first followed by fractional x-radiation if general condition permits.
2. If unoperable because of EXTENT OF GROWTH, give x-radiation first, followed by radium, if possible.

Adenocarcinoma of the fundus, Stage 2, which under radiation becomes operable, should be given the benefit of panhysterectomy not sooner than three months following the end of all radiation treatment.

Cases which have been declared inoperable because of poor general condition may subsequently become operable and should have panhysterectomy not sooner than three months after the end of all radiation treatment.

* *

MORTALITY AMONG THE SURGEONS

In a report concerning the work of The American Board of Surgery, Dr. Evarts A. Graham presented some interesting facts at the meeting of the American Surgical Association held in May of this year. Up to the time of this report, 938 of 1,570 applicants had been admitted to the Founders Group of the Board. The number of candidates submitting to examination was 509 but 86 of these had just completed the second part of the examination during the first part of May. Of the 423, there were 29.3 per cent failures. The mortality is really between 40 and 50 per cent inasmuch as many do not even qualify for the examination following investigation and scrutiny by the Board.

Being of considerable interest, Dr. Graham dwelt on the "astoundingly weak" knowledge of pathology — and he made particular reference to gross pathology — of the men taking the Board examination. His experience with those he personally examined was, as he stated, "not unique" since other examiners in the same and other sections of the country met with the same experience.

To quote Dr. Graham, "I look upon this observation (weakness in pathology) as a most astounding discovery. I would not have thought it possible that young surgeons who have otherwise obtained a pretty good training could have been so deficient in one of the fundamental features of surgery, mainly, pathology. I feel that the fact that the Board has made this discovery will accomplish much good, and if it has not accomplished anything else, the fact that it has noted the woeful lack of pathology training has perhaps more than justified its existence."

The need of more thorough graduate training in pathology is obvious. Regarding the other features in relation to surgery, the Board found the applicants to be quite competent in their clinical surgery and in anatomy.

Dysmenorrhea*

CARL E. JOHNSON, M.D.,
New Haven, Conn.

Dysmenorrhea like dyspnea is a symptom, not a disease. Dysmenorrhea is defined as being disabling pain with menstruation due to inherent abnormalities of the physiologic function or structure of the female pelvic organs.

Brown[1] states that — "Among ancient peoples such as the Egyptians considerable attention was paid to it and the Ebers Papyrus contains prescriptions for illeviating menstrual discomfort, as does the Kahun Papyrus which says, 'If thou examinest a woman who has pains in one side of her hypogastric region, then thou shalt say thereto: it is (due to) a disorder of her menstruation. Now after it has appeared, then thou shalt prepare for her: crushed onion, sbt, sawdust of pine; the hypogastric region is bandaged therewith.' " This quotation is from the earliest known medical writings of the human race and dates back to about 1900 B.C.

Scanzoni[2], in 1861, gave us a description of dysmenorrhea that is still a classic. He says the symptoms are ordinarily as follows: "Some days before the appearance of the menses, the patients evince a surprisingly bad humor; they are downcast and capricious, avoiding company, seeking solitude, and complaining of a general disturbance which they cannot clearly define. Afterward, simultaneously with various digestive difficulties, such as eructations, flatulences, constipation, etc., they complain of a very troublesome headache, often limited to one or the other side of the head, to which is often added visual difficulties, particularly photophobia, accompanied by a hypersecretion of the lachrymal glands. By degrees painful sensations in the organs of the pelvis are perceived, such as draggings, shooting pains, which are limited to the uterine region, or radiate toward the thighs, the seat and the loins. Very often they also extend to the breasts, although with less intensity. To these accidents a convulsive constriction of the uterus is frequently added with a very disagreeable pruritus of the vulva, more frequently still a vesical and rectal tenesmus. The urine is straw-yellow, scanty, almost always alkaline, and contains, at the end of a certain period, a great number of fungi and vibriones. All these symptoms gradually increase, and attain their maximum of intensity immediately before the appearance of the menstrual flux; they generally moderate quite rapidly so soon as the flow is well established. There are even cases where patients who just before were suffering intensely, are perfectly well some hours after the commencement of the menses, and apply themselves immediately to attending to their affairs, though for some days formerly this had been completely impossible. With the majority of patients, these attacks are repeated at each period with more or less intensity. Sometimes, however, they suddenly disappear, not again to return, without our being able to discover the cause of the cure."

The incidence of dysmenorrhea has been studied by many writers. Brown[1] in a questionnaire answered by 29 Universities and Colleges, found that of 31,309 students ranging from 16-26 years of age 45% claimed some type of dysmenorrhea and 15% had a severe type.

Lakeman[3] made a comparative study on healthy girl students and girls employed in various industrial plants. The industrial girls showed a much higher percentage of severe complaints. The author does not draw any definite conclusions but she suggests that industrially employed women might possible seize every available opportunity to absent themselves from work.

Here in New Haven quite the opposite has been my experience for girls who are dependent upon their jobs for a livelihood tend to minimize or even claim other disability rather than admit their dysmenorrhea.

Of 556 women applicants examined for the Southern New England Telephone Company by some 20 different physicians throughout the State of Connecticut 33% admitted mild pain and 8% admitted moderate pain during the menstrual period. It is interesting to note that this total of 41% is very similar to that of 45% obtained by Brown in his questionnaire covering more than 31,000 college students who were of the same age group.

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

For clinical purposes dysmenorrhea may be classified into two large groups. (1) primary or essential dysmenorrhea in which there is no gross demonstrable pelvic pathology and the pain has been present since the onset of menstruation and (2) secondary or acquired dysmenorrhea where definite pathology such as retroflexion of the uterus, endometriosis, and pelvic inflammatory lesions can be shown to be the cause of the menstrual suffering. In this connection it is important to bear in mind the frequent association of hypoplasia, dysmenorrhea, and infertility.

Treatment depends upon the findings of a *complete* history and *thorough* physical examination. To justify my commenting on this subject the medical attendant must be cautioned not to treat this malady too lightly and second to secure a complete study of each patient.

The many therapeutic measures suggested for dysmenorrhea fall roughly into three large divisions namely surgical, endocrinological, and medical.

For the sake of completeness the surgical treatment will be briefly reviewed, but the purpose of this paper is to emphasize what can be accomplished by simpler measures. The first of these surgical treatments is dilatation and curretage of which dilation is undoubtedly the effective agent. Many forms of stem pessaries have been designed and among others Curtis[4] and Adair[5] vigorously warn against their use because of the danger of endocervicitis and serious forms of ascending infections. Plastic operations on the cervix; correction of displacements, neoplasms, and congenital anomalies; presacral sympathectomy; and hysterectomy may all have their proper indications.

Endocrine therapy is based on the hypothesis that dysmenorrhea is due to an endocrine imbalance, and consequently several of these endocrine substances have been used, among the most recent one being progestin. Fluhmann[6] in a quantitative study of the estrogen and progestin content of the blood stream of 18 patients suffering with dysmenorrhea found that there is neither a deficiency nor excess of either of these substances. Meigs[7] says that "treatment of dysmenorrhea with hormones is unsatisfactory."

Those of you who saw the article by Greenhill[8] in the recent Journal of the American Medical Association were undoubtedly as astonished as I was to find the male characteristics induced in women by the use of testosterone propionate and even more impressed by the fact that Greenhill[8] feels that some of these changes such as the male voice may remain permanently. It is not surprising to find him concluding that androgenic therapy in women should be approached with caution and is not to be recommended until the danger of virilism can be eliminated or controlled.

The medical treatment may be divided into two parts. First, that concerned merely with relief of pain and relaxation of spasm. Second, that directed toward constructive relief of the dysfunction.

In the former type of treatment may be included antispasmodics, (atropin, hyocyamus, and benzyl derivatives); sedatives, (barbiturates); analgesics, (salicylates, antipyrene, acetanilid); and narcotics, (codeine, morphine, and alcohol). Because of the sad end results which both patient and physician have experienced from the use of narcotics these substances certainly cannot be considered in the modern therapy of dysmenorrhea.

(b) The second large division of medical therapy includes those measures directed toward *constructive* relief of dysmenorrhea including a proper amount of exercise.

Anemia, constipation, inadequate or deficient diet, fatigue, nervous tension, pelvic congestion, any or all may be partially or totally responsible for dysmenorrhea. Emphasis is made here of the importance of adequate treatment of any of these symptoms.

Several years ago Dr. Ruth Ewing[9] in a study of some 10,000 female employees of the Metropolitan Life Insurance Company found that the incidence of the congestive type of dysmenorrhea associated with constipation was quite high. 500 girls with painful menstruation were placed under her care. Her treatment consisted of improved hygiene and corrective exercise and she found that about one half of these cases of the congestive type could be cured by these measures. Even the severe cases were improved.

Miss Wilma Haynes[1], the head of the physical education department at Stephens College has studied menstrual disorders with a special interest for many years. A summary of her deductions which coincide identically with mine are as follows:

Most students who have had dysmenorrhea previous to entering college improve in the special classes for these difficulties. The class exercises are arranged to improve the general tonus of the body, emphasis being put on strengthening the abdominal muscles especially as they relate to ptotic conditions. So called relaxation exercises are a part of each lesson because it is felt that a great many menstrual difficulties are due to tension. Congestion or heaviness in the pelvic cavity during the period is a frequent complaint. Students report improvement of this condition after a few lessons. It is interesting to note that just before vacations, when there is a great deal of excitement, and during vacations when students have gone at a rapid pace, there is usually an increase in menstrual pain. Generally speaking, this is especially true of the high strung easily fatigued students at examination time. Overloaded schedules, both academic and extra-curricular, with the accompanying nervousness and exhaustion, frequently bring about difficulties of profuse menstruration. Daily rest and, later, relaxation activities such as swimming with frequent rest periods during the activity, are important methods of treatment. Needless to say, an attempt is made to reduce the daily load.

In studies made at Stephens College a close correlation between dysmenorrhea and constipation was substantiated. (Cases in which this does not happen are rare). Exercises in groups or classes should always be supplemented by individual attention.

Too often I hear reports from patients that their doctors say these disturbances do not mean anything; that it is normal, that they will outgrow it and that the suffering is what the "female of the species" should expect.

The opposite extreme to this cruel indifference can likewise lead to chronic invalidism. Hence the success of medicinal compounds such as that of Lydia Pinkham and the addictions of patients to the use of injurious drugs.

Generally speaking, the whole question of menstruation should be explained to women simply and carefully. False ideas are common even among college students. It has been my experience that one of the valuable contributions which can be made to the health of women is their early education in the whys of menstruation.

Doctors too often do not take time to sit down with women and educate them in these matters; so the treatment becomes only a means of relieving pain for the time being, and the patient leaves the doctors office with the same false ideas and attitudes she had when she entered. I believe that a great contribution to the whole subject can be made by the doctor and the trained physical education teacher. What seems to be a superficial thing in the minds of adults can be serious in the adolescent group.

In conclusion then, dysmenorrhea may be divided into two general types: first, primary with no demonstrable lesion; and second, the secondary or acquired showing definite pathology. Treatment of the primary group consists of constructive therapy such as correction of anemia, and constipation as well as exercise to condition the body muscles. This may sometimes be supplemented with antispasmodics or analgesics. Treatment of the secondary group consists of proper care of the pathology concerned.

BIBLIOGRAPHY

1. Brown, Journal of Missouri Medical Association 35:299, 1938.

2. Scanzoni, A Practical Treatise on the Diseases of the Sexual Organs of Women. Translated from the French by F. W. Gardner P. 343, 1861.

3. Lakeman, New England Journal of Medicine 209: 237, 1933.

Curtis. Textbook of Gynecology 3rd Edition P. 392, 1938.

5. Adair, American Journal of Obs. & Gyn. 25:750 1933.

6. Fluhman, Endocrinology 23:393, 1938.

7. Meigs, Med. Clin. N.A. 18:1143, 1935.

8. Greenhill, Journal American Medical Association 112:1573, 1939.

9. Ewing, Personal communication.

Summary of Gynecological and Obstetrical Papers*

JOHN FRASER, M.D.,
Montreal, Canada

I feel very happy indeed to have this opportunity and pleasure of being here today. I thought the program arranged for us was magnificently done.

Dr. Thoms, in his very beautiful film, reviewed the whole question of x-ray pelvimetry and made the subject so simple and understandable that he deserves our utmost admiration. Two men deserve the credit for x-ray pelvimetry and Dr. Thoms, of course, is the pioneer.

When a women dies in childbirth there are three or four primary causes. Sepsis accounts for 60% of the mortality and then there are the toxemias, dystocia, hemorrhage, etc. In the last month of pregnancy we believe the head should be in the pelvis. If it is not, we should determine why it is not there. In the past we have observed with a great deal of interest the pathway the child has taken during gestation. In determining this pathway our powers of observation rank far above any mechanical device. There are three things we want to know: (1) the kind of pelvis; (2) the baby and its head; (3) what she (the mother) can do with her uterus. There is a great deal we can learn from the physical examination.

A history of dysmenorrhea looms large, for I have never seen a woman with dysmenorrhea who had had an uncomplicated pregnancy. We can tell much with routine examination. We can try the outlet with our fist and the inlet with our fingers. We can map out the outlet. We also want to know about *her* soft parts; whether or not labor has begun; and the type of head (of the baby). We have means, such as castor oil, to get the head down in the pelvis. When we have done all these things and they have not been sufficient to our purposes, then we turn to x-ray. He (Dr. Thoms) of all men deserves our thanks, for he has put in our hands a fair, simple method for measuring the pelvis and the baby's head. He has outlined a scaffolding for us — the anthropoid, the round, the oval, the flat pelves. He has set an objective for us to reach up to. He has established that there are patterns typical of the pelvis in healthy women and patterns for women who are not healthy, women who have had rickets.

All of us have heard of mishaps resulting from too large babies. X-ray can lift us out of that trouble; it will be a wonderful help. The multiparous woman is looked upon as a safe performer. Yet we know that a Para IV or Para VII has got into a great deal of trouble with a large baby . . . This is the first time we have had the opportunity to say to Dr. Thoms how much we admire his method and the simplicity of his method, and we thank him.

This is an excellent program (for the prevention and treatment of cancer of the cervix). Dr. Miller has outlined for us. There are some aspects I should like to deal with briefly. One can briefly put the situation like this: There are only two things you can do for cancer of the cervix; you can turn her over to the surgeon to perform a panhysterectomy; or you can radiate her. The pendulum has been swinging away from surgery. Not so long ago cancer of the cervix was a death certificate; yet we know now that 20% are being cured; whereas 50% of the early cases are being cured. The League of Nations reports an increased number of cures. At the same time it is fair to say that we are operating on carcinoma when operable and are successful. Victor Bonney of London reports a series of 1500 cases. He lost 60%. There were some nasty complications; some bad fistulae and would have been better off dead. Then came radium. Although radiation may not give 5-year cures, yet it gives great relief.

We have been talking of a plan of campaign this morning. The campaign of *we* medical people is what counts. It matters not if Dr. Miller and I save 15-20% of them in our clinics.

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

He put his finger on the spot when he said this is a team job. We cannot be perfect. No man can be a specialist in everything. When I say that this is a comprehensive thing, I mean that Graves in Boston treated the cervices of many women and showed the significance of the tear. It is in multiparous women we see it (cancer). You will examine then, people. You will clear up the cervices.

You are aware of the work of Schiller. He evolved the Schiller test for diagnosis of the early cancer of the cervix. If nothing further is accomplished by Schiller's lugol solution than further examination of the uterus, then it merits a great deal! He has shown a picture of change of cells in the uterus that is indicative. He feels he has found an earlier indication than invasion . . . . I'll be interested to see what the results of this program (Dr. Miller's program) are.

Now, Dr. Johnson, I was very much interested in dysmenorrhea. I think that is the fairest presentation I have heard in a long time. I thought he (Dr. Johnson) soft-pedalled in the right spot and did not over-emphasize any particular therapy. *That* young woman with primary dysmenorrhea represents to me a problem of the greatest perplexity to deal with. It (dysmenorrhea) is a reflection of her emotional state and of the home she comes from. She requires a strong, cheerful physician. The surgeon should not touch her. Many a uterus as small as a fishhook has been dilated. This girl's other organs probably have a size relative to her uterus. She likely has a small heart and a high threshold for pain. Delayed maturity will catch up if she only comes into the proper environment.

A mother brought her 19 year old girl who suffered from dysmenorrhea to the hospital and wanted me to operate. She was a frail, little weak-sister with delicate transparent skin. Now I said, "See here, first we are going to have a thorough examination." I had an older physician go over her. He reported she was sound. Therefore, it was decided that the next time she had her menstrual period I was to be notified at once. When this time arrived I came and found her in agony and her mother in agony, too. I said to the nurse, "Give her an enema, slowly, but lots of it." Then we left her with her rectum distended, and without a bed pan, and we went far enough away so we could not hear her call. We dilated the bowel which had heretofore been made spastic each month by morphine. After some while we returned and she was smiling. The dilation of the bowel had caused the pain to go, and this illustration reveals the power of the reflex from the rectum on the behavior of the uterus. I trotted her out without thought of an operation; and she has had no operation to this day, but quite often she has had an enema.

COMING MEETINGS

January 3, — 10:00 a.m. Meriden Medical Society. Meriden Hospital. "Pneumonia" — Samuel J. Goldberg, New Haven.

January 3, — 9:00 p.m. Torrington Medical Society, Charlotte Hungerford Hospital. "Pneumonia" — Clarence L. Robbins, New Haven.

January 18 — 8:30 p.m. Fairfield County Medical Association, Pickwick Arms, Greenwich. "The Laboratory in Infectious Conditions" — John C. Leonard, New Haven.

January 25 — 7:00 p.m. Connecticut State Medical Society, Hartford Club, Hartford. "American Medicine and the National Government" — Morris Fishbein, Chicago.

January 26 — 8:00 p.m. Manchester Medical Society, Manchester Y.M.C.A. "Pneumonia" — Francis G. Blake, New Haven.

February 6 — 8:30 p.m. Fairfield County Medical Association, University Club, Bridgeport. "Wounds-Treatment and Complications"— Hugh Auchincloss, New York.

March 5 — 8:30 p.m. Bridgeport Medical Society, University Club. "Pneumonia" — Russell L. Cecil, New York.

March 12 — 8:30 p.m. Fairfield County Medical Association, Stamford Hospital. "Principles of Serological Treatment" — Russell L. Cecil, New York.

May 14 — 8:30 p.m. Fairfield County Medical Association. Pickwick Arms, Greenwich. "Modern Trends in Chemotherapy" — Francis G. Blake, New Haven.

May 22-23 — Connecticut State Medical Society, Hotel Bond, Hartford, Annual Meeting.

Further Studies in the Therapy of Acute Anterior Poliomyelitis

C. L. THENEBE, M.D. and M. S. HIRSHBERG, M.D.,
Hartford, Conn.

The horror of the maiming associated with infantile paralysis tautens the heart strings of the public greater than any other disease known to man.

We fully realize that any workable measure in prophylaxis would be the ideal objective. Since such a procedure is at present not avaliable, then any therapeutic plan which could prevent the progress or the appearance of paralysis after the disease has developed would occupy the second role in importance. According to recognized authorities, the usual expectancy of paralysis in patients presenting symptoms of acute anterior poliomyelitis is approximately 40 to 60%.

A previous preliminary report on 33 cases of preparalytic poliomyelitis treated with intramuscular injections of sterile milk[1] revealed 6% of the cases showing appreciable paralysis or weakness under this form of therapy. The unusually low incidence of this sequel of the disease in this series seemed to present a step up toward the right goal, since the percentage was lower than in those cases treated with human convalescent serum (20.4%)[2].

Since reporting the above series, we have accumulated twenty-seven additional cases from 1932 on, treated with the intramuscular injections of sterile milk to effect the non-specific protein reaction. This accelerates the body defense mechanism with a febrile reaction which also aids in combating the infection. In addition to the milk, dehydration measures were added to reduce any overwhelming edema in the cord or cranial nuclei which might tend to destroy these ganglion cells. At first 50% glucose was used, to be entirely supplanted later by 50% sucrose solution[3]. Limitation of fluid intake was used in conjunction with this.

At present our routine is as follows: aside from the initial diagnostic lumbar puncture and absolute bed rest, 1 to 4c.c. (according to the age of the patient) of sterile milk is injected intramuscularly at 12 to 24 hour intervals for 3 or 4 injections; fifty (50 to one hundred (100) c.c. of 50% sucrose solution (less in infants and young children) are injected intravenously at 12 hour intervals for 5 or 6 injections; the fluid intake over a period of 72 hours in limited according to the age, the top limit being 950 c.c. per day for adults. Dehydration is carried out for longer or shorter periods according to the patients condition.

Since 1932, 74 cases of poliomyelitis have been admitted to the Isolation Division of the Hartford Municipal Hospital. For clarity these cases were divided as follows:

Group I-27 cases (36.4%) admitted in the preparalytic stage.

Group II-47 cases (63.6%) admitted with weakness or paralysis.

Group III-35 cases (47.3%) of group 2. These were the spinal type of poliomyelitis.

Group IV-12 cases (16.3%) of group 2. These were the bulbar type. One case (1.3%) of this group was a combined bulbar and spinal type, while another presented bulbar and encephalitic involvement.

During this period, 5 cases of Landry's ascending paralysis were admitted. There is no definite reason to suspect that these cases had the poliomyelitis virus as the exciting etiological factor.

The statistics of each group follows: The preparalytic group comprised 17 males and 10 females. The age group represented 1 case at 4 months, 2 at 4 years, 1 at 5 years, 4 at 7 years, 4 at 8 years, 2 at 9 years, 3 at 10 years, 3 at 11 years, 1 at 12 years, 2 at 13 years, 1 at 14, 15, 19 and 27 years, respectively. No subsequent paralysis developed following admission in any patient of this group. One (3.7%) of the 8 year old group of patients who was admitted to the hospital after 4 days of illness developed a bilateral weakness of the quadriceps extensors, which weakness subsequently disappeared entirely before hospital discharge. The low incidence of weakness and the absence of paralysis in this group was beyond expectations.

Of the group 3 cases, twenty four (31.9%) were admitted paralyzed. Fifteen were unimproved and eight improved upon discharge. One case recovered completely. Those receiving the therapy in this group showed a greater improvement than those who did not.

The remaining eleven cases (15.3%) of group 3 were admitted with muscular weakness but without paralysis. This entire group received the therapy. Eight (73%) recovered completely and the remaining three (27%) were definitely improved upon discharge.

Of group 4 comprising 12 cases, 3 (25%) recovered completely, 1(8.3%) was unimproved, 6 cases (50%) were improved and 2 cases (1 bulbar and 1 bulbar-encephalitic) died, the mortality being 16.7%. (All of this group received the therapy excepting the bulbar-encephalitic case.) We believe that the mortality in this group is also very low. All expired in the Landry's ascending group of cases. Four of these cases received one injection of 1 to 3 c.c. of sterile milk.

Taking the group as a whole, i.e., the 74 cases, there was a mortality of 2.7%, complete recovery in 52.7%, improvement in 22 9% and no improvement in 21.6%.

We have extended the use of the therapy upon cases of primary and secondary encephalitis, particularly those following or accompanying epidemic parotitis, rubeola and influenza, and have been gratified for the most part with the end results, especially when the therapy was administered early. Further study, however, is truly in order for enlightenment.

In some of the patients who had developed muscular weakness or apparent paralysis within twelve hours after the onset of the symptoms of infantile paralysis, almost complete recovery of the involved muscle groups has been observed within twenty four hours.

Again, the older patients will often comment that their headaches have subsided either during or after the completion of the first intravenous treatment.

Of course several considerations must be borne in mind. We know that the preparalytic cases reported are few in number. The cases have not been controlled and the infection could have been mild. However, 63.6% of the cases admitted during the same period showed paralysis or weakness. Perhaps 40% of the preparalytic cases reported would not have developed paralysis, even without the treatment. Finally, the possible ordeal of the therapy should be heeded. *However, we believe that the absence of paralysis in the group, under our form of therapy, will more than equalize the final objection.*

The salient reason for reporting these cases is to make the therapy known so that other investigators may ascertain its worth. Otherwise, because of the dearth of cases, an epidemic excepted, the study would extend beyond a life time before sufficient cases would be accumulated to be of true value.

Summary

1. Twenty seven consecutive cases of preparalytic infantile paralysis (36.4% of the total admissions) treated with non-specific protein (intramuscular sterile milk), intravenous 50% sucrose and dehydration (restricted intake) are herein reported. There was no paralysis nor mortality in this group. One case developed weakness, which subsequently disappeared entirely before hospital discharge.

During a simultaneous period, 47 cases (63.6%) were admitted with either weakness or paralysis.

2. The early administration of this therapy is advocated.

3. The therapy was used in cases presenting muscular weakness and paralysis upon hospital admission with apparent arrest of the process sooner than is usually expected. A rapid recovery was striking in many instances. This was particularly true in the group admitted with weakness only. 73% of these recovered completely and the remaining 27% were improved. In the paralytic group ganglion cell destruction had often completed before hospital admission. In these cases the results would be disappointing with any therapy.

4. Of the 47 cases admitted in the stage of weakness or paralysis, including the bulbar cases, twelve (25.5%) recovered completely, 17 (36.1%) definitely improved, 16 (34%) were unimproved and 2 (4.2%) died. In the entire group (74

cases) there was a mortality of 2.7%, complete recovery in 52.7%, improvement 22.9% and no improvement in 21.6%.

5. Aside from poliomyelitis, we have used the therapy in primary and secondary encephalitis with gratifying results in most cases, which, however, were few in number.

6. Further study on a larger scale would be advantageous in evaluating this therapy, both in poliomyelitis and encephalitis.

BIBLIOGRAPHY

1. C. L. Thenebe, M. D., V. P. Cenci, M. D. Treatment of Acute Anterior Poliomyelitis with Non-Specific Protein; N. E. Jour. Med., Vol. 207, No. 20, pp 880-884, Nov 17, 1932.

2. Kramer, S. D., Aycock, W. L., Solomon, Chas. L. and Thenebe, C. L. Convalescent Serum Therapy in Preparalytic Poliomyelitis; N. E. Jour. Med., Vol. 206, 432. Mar. 3, 1932.

3. Bullock, L. T., Kenney R., Gregerson, M. I. The Use of Hypertonic Sucrose Solution to Reduce Cerebrospinal Fluid Pressure without a Secondary Rise. Am. J. Physiol., 109-17-1934.

We are indebted to Drs. Aaron Bobrow and Eugene Lamoureux for accumulating the statistical material and aiding in construction of this paper.

⁂

MEDICINE — AND MORE

"I know of no calling which offers such a wide diversity of intellectual pleasure as that of medicine, not alone in its art and science, with an ever increasing range of new developments, but in human behavior, psychology, sociology, economics and related activities; we follow a most useful calling, an interesting occupation filled with new and striking problems and one of the best because its only aim is the benefit of man. Medicine is the most ancient of professions, being older than Christianity and antedating the inception of civil law. It has its own system of rewards and punishments, its own disappointments and its own glories. It is a profession that has a broadening influence on the human mind and is characterized by a most splendid charity. It is an acquisition in the best tendencies and a protection against the worst tendencies. It constructs no trusts; it founds no monopolies; it excludes no qualified practitioner; it retains for its profit no valuable discovery and it has no standing room for the quack, the scoundrel and the charlatan. Its best work is done in the light which beats upon its throne, not in the arena of politics encouraged by the cheers of thousands, not in the seclusion of the cloister sustained by the hope of eternal joy, but in the storm and wind swept country, in the streets of the village, in the boulevards of the city, on the desolate field of battle where pain and pestilence, illness and misery are combated often with none but God to see it. It furnishes a curiously checkered life, a life in which storm clouds alternate with sunbeams. With the exception of the ministry it stands closer than any other calling to the secret of eternity and watches death ever busy with her shuttle as she weaves her somber threads into the woof and warp of the affairs of men. It seeks to mitigate human suffering, to prolong human life. These have ever been its watchwords, are still and always will be, constituting its cloud of smoke by day and its pillar of fire by night. One should enter such a profession with properly exalted ideals; with a belief in its greatness, its dignity, its stability, its real importance, its essential strength. One should resolve to learn to observe, to compare, to analyze, to study, to think, to avoid formulas, to cast out sordid thoughts, to repudiate shallowness, advertising and vain pretensions. In short, to be a worthy disciple of Aesculapius, reflecting honor and credit on the profession and deriving from it the happiness that makes life worth while, being held in grateful remembrance by those whom one has served and in respect and esteem by the confreres with and among whom one has lived and worked."

Irvin Abell, M.D.
From New Haven Address, Jan. 1939

The PROFESSIONAL EQUIPMENT Co.
X-RAY
SUPPLY and SERVICE SPECIALISTS.
KELEKET APPARATUS.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

MID-WINTER DINNER

The
Connecticut State Medical Society

HARTFORD CLUB, HARTFORD

Seven O'clock

Thursday, January, 25, 1940

•

SPEAKER:

MORRIS FISHBEIN, Editor

Journal American Medical Association

"American Medicine and the National Government"

•

TICKETS - TWO DOLLARS

•

Members may bring guests - Ladies especially invited.

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD
Stanley B. Weld, M.D., *Editor-in-Chief*, Hartford
Sidney G. Davidson, M.D., New Haven
Frank Stafford Jones, M.D., Hartford
Charles Mirabile, M.D., Hartford
Oliver L. Stringfield, M.D., Hartford
Herbert Thoms, M.D., New Haven

COUNTY NEWS EDITORS
Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Maurice Moore, Norwich
Tolland — Donald M. Beckwith, M.D., Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.— Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.— Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

INDUSTRIAL PATHOGENESIS

The control of disease has progressed directly in relation to increasing knowledge of the causative factor — be it bacterium, virus, allergen, nutritive deficiency or metalbolic dysfunction. Peculiarly in industry we are dealing for the most part with a known, but entirely different kind of etiological principle, usually with a toxic chemical compound or element or with a physical agent.

Typhoid is spread by organisms, usually from an isolated source, finding their way via a well-recognized channel to the individual members of a fixed population. Again in industry the process is different. The individual worker comes in contact with a fixed and toxic environment. Instead of allowing the etiological agent to find him, we bring him to the agent.

It is the recognition that in either case the pathogenesis is essentially the same, which is enabling us to forge ahead faster in the control of industrial disease. Doctor George H. Gehrmann's article on this issue, entitled "Industrial Poisons — Physiological and Clinical Considerations," cites a few instances to illustrate how the knowledge of the mode of action of the toxic milieu underlies the effective diagnosis, treatment and prevention of industrial disease.

That there are thousands of toxic compounds in use in industry, as he points out, need not discourage us. They are relatively easily isolated. We often know beforehand what they are. Lead is lead. It is true that the specific factor in a toxic mixture may need running down, but how different is the problem compared to the epidemiology of a disease caused by an elusive virus, such as poliomyelitis!

The mode of action of a substance is ascertained in a relatively simple manner by animal or other experimentation, once we know what it is. The humble patch test, when properly used and evaluated, screens out workers susceptible to contact dermatitis, the most common of all industrial disease, thus fulfilling a function similar to that of the Schick test in its field. When environmental atmosphere cannot be adequately changed by air conditioning as in unavoidably high temperatures, we can often lay down rules, as Dr. Gehrmann indicates, for selecting the most fit individuals for employment. But such instances are relatively uncommon.

More frequently the problem in industry is the mere mechanical removal from the environment of a known substance or its entire elimination by substituting some less toxic ingredient, or we have but to educate workers to clean hands before eating, wear masks or what not; innovations fraught at times with the difficulty of overcoming human inertia, but relatively simple measures, and ones we know will be effective because the etiological agent is where we can get at it — in the very environment in which the worker works.

⁂

ENTER — THE CONNECTICUT HOSPITAL ASSOCIATION!

The Connecticut State Hospital Association appreciates this opportunity of being a part of the State Medical Journal. In a very large measure, the practice of medicine and the operation of a hospital are interdependant. In their relations they are concerned with the same problem — giving adequate care, that their patients may be quickly restored to normal health.

The physician, with his office, his reception room and his examining room seems far removed from the boiler room, the laundry, the kitchens and the other hospital departments, but, when his examination of his patient indicates the need for a prompt operation, he and the hospital meet on common ground, namely, prompt and efficient service for the patient. It is imperative that these various departments of the hospital work with him and, by the same token, he must have a corresponding interest in the operation of his hospital.

It is well then that these groups, each having their own peculiar problems, should work together for their mutual helpfulness and their common objectives.

This cooperative venture on the part of our two organizations opens the way for the development of a finer public relationship and it is the hope of the members of the Hospital Association that much good may come to both organizations.

MEDICAL NECROMANCY

The degree of happiness with which one undertakes another year of work — and play — will depend upon the enjoyment that obtains from looking down the vistas spread out ahead. To wish our readers a Happy New Year is trite, even to our youthful existence. Contemplating the plight of so many of our colleagues in Europe and Asia leaves us little happiness, save that found in a sense of security engendered by miles of ocean separating them from us. Even our own plight under a government attempting to discredit the practising physician is not one altogether to be coveted. And yet, to each one of us, our patients will continue to turn for that one possession without which there can be little happiness, — health.

The past year has seen much of interest transpire within our Society. In the halls of the Capitol we needed no paid lobbyist, no brilliant legal talent, since our own Executive Secretary accomplished all we asked and more too, and utilized such talent which became his for the asking. A dignified criticism of the Wagner bill was forwarded to our Congressmen, one which recognized the possibilities for good but condoned the methods to be used. That bill is past history but another session of Congress is now convening and health legislation is uppermost in its mind. To the credit of those who make this nation's laws be it said that at last they are turning our way and asking for advice in solving this difficult problem.

The House of Delegates of our own State Society has given its mandate for a full time secretary and the Council has selected the man. On February 1st Doctor Creighton Barker becomes the servant of this Society. No one knows better than he what this implies. In this day of rapid changes and the trend — world wide in scope — toward governmental paternalism and the false suicidal doctrine that the "State" can provide a service and a security that the people cannot otherwise obtain, the Connecticut State Medical Society needs a man of vision, alert, fortified, friendly, to guide it at all times. Such a person is Creighton Barker. He should have the hearty support of every member during 1940.

The Journal has grown wiser during the past year. In its efforts to please all it has displeased some. Comments on its contents have been forthcoming from the most unexpected sources. It is still a struggling infant. 1940 will see it representing the Connecticut Hospital Association as well as the State Medical Society. This is a step in the right direction for Connecticut has many problems common to each group and a better understanding between the two can but work for the greater public good. The best health of our own citizenry is our common goal. To the Connecticut Hospital Association we extend a welcome. May the coming year bring to each member of both Associations true happiness found in doing the tasks ahead.

FEDERAL GRANTS

There is a present philosophy of progress which uses the national government as an instrument to influence social change. Two well defined methods are used by the national government to bring about such changes. These are cooercive legislation and federal subsidy for state activities.

Federal grants for public health in the State of Connecticut now amount to about a quarter of a million dollars a year and ideas and principles with respect to these grants are confusing and opinions vary with the temperament of individuals.

There are the Rugged Materialists who know that Connecticut carries a heavy burden of Federal taxation and feel that any part of it that can be recaptured for State purposes is desirable. The Viewers With Alarm anticipate an undermining of democratic government by the extension of social projects under beneficient guise by a Federal government that pats the states on the head with one hand while the other is in the states' pocket. Then there are the Blithe Enthusiasts who will accept any sum from any source for any public health project with the pious hope that the expenditure will, somehow, do some good. Last, and perhaps too scarce, are the traditional Connecticut Yankees who look every horse in the teeth and want to know what will happen when the stream of Federal largesse is cut off and the State is faced with the necessity of raising and spending its own money to carry on activities that have been begun by gifts. They know there is a difference between accepting grants for highways and buildings and grants for service projects. Once a highway or building is completed, except for modest expense for upkeep, it is in a sense a net gain. This is not true of programs of service which, when once put into the pattern of government are not easy to take out.

It is scarcely to be hoped that these and other divergent opinions will ever be reconciled but a better knowledge of the State's needs would be helpful, for on so difficult a subject it is well to remember that sentimentality is not the best adviser and truth should light the way.

C. B.

ATTENTION ADVERTISERS!

Elsewhere in this issue (see Letters to the Editor, page 48) appears a very interesting letter from one of our largest advertisers. The interest in the Journal on the part of this advertiser as evidenced by the general tone of the letter is highly gratifying. Yes, we have been told by the Cooperative Medical Advertising Bureau in Chicago that our Journal is one of the finest state journals in the country. It was on that basis that we secured some of our new advertising contracts this past year. Now our circulation is taking a jump over the 2,000 mark due to the addition this month to our mailing list of members of the Connecticut State Hospital Association. The aim of the Journal has been at all times to provide a medium of expression for medical talent in our own State and to stimulate our membership by keeping it informed on all pertinent matters of a medical nature, whether legislative, scientific or social. To this is added on its advertising pages a dignified, attractive presentation of reliable products of interest to members of our Society.

The advantages of advertising in the Journal have been stressed ever since the first issue appeared in August 1936. There is no other medical publication, except the Journal of the American Medical Association, which reaches so many physicians in Connecticut and has in addition an exchange list including all the other state medical societies, many libraries and several foreign countries.

Connecticut physicians do take notice of advertising copy in the Journal. Some firms have carried on a coupon campaign in the columns of state medical journals and by their results have decided whether or not such advertising had any merit. Such a coupon is not a fair criterion. Physicians in hide bound New England do not cut coupons from journals as a pastime nor is an evidence of their interest in a product. This method of advertising is out moded. Present a dignified, attractive advertisement of a sound, accepted product and the desired result is inevitable. Our circulation of itself guarantees this.

The Journal is read all over Connecticut. If you do not believe it, make a gross error in your advertising copy and see how quickly you will hear from it. Start something new, a little unusual, perhaps not exactly conventional, and you will hear from our readers all over the state.

Letters such as the one by the Professional Equipment Company of New Haven are most welcome and appreciated. We invite other advertisers in our columns to express their opinions.

☆☆

THE ACHILLES HEEL

Notwithstanding the material mailed to individual physicians and all the publicity given to it in the Journal of the American Medical Association, to some the National Physicians' Committee for the Extension of Medical Service remains somewhat of an enigma. It should not. Its purpose has been frankly stated, to "familiarize the general public with its program and policies, private and public health needs, — the achievements of and the position occupied by American Medicine, — the services rendered by physicians, — how and where these services are available." Listed on its executive board are such prominent leaders in American Medicine as Edward H. Cary of Dallas, Austin Hayden of Chicago, former president of the American Medical Association, Irvin Abell of Louisville, and Roger I. Lee of Boston, all staunch supporters of the American Medical Association.

The National Committee has been formed as a sort of ex cathedra organization of the American Medical Association for the purpose of informing the public concerning the ideals and policies of the American Medical Association. Many have asked the question as to why the Association could not handle all this work itself without an attempt to thus camouflage it in an independent voluntary group. The reason for this seems to be to avoid income taxation on the part of the American Medical Association, such taxation being likely if any considerable effort was made by the Association to influence legislation, and because the American Medical Association is unwilling to accept donations from private sources to further any activity of this nature.

A broadgauge nationwide educational program has been planned and the preliminary steps have been taken to put it in operation. The daily, weekly and trade papers will be utilized, also magazines, radio, public meetings, and the cooperation and services of other agencies or organized groups. For all this funds are required. You have been afforded the opportunity to contribute as each one of you sees fit. It is not a tax but do not forget this, a new health bill will be presented before the next Congress which meets this month and its merits will depend upon a knowledge of facts, a knowledge shared by every voter in this country as well as by our spokesmen in Congress. The degree of the effectiveness of the National Committee will be measured by the extent of the moral and financial support contributed by American physicians.

☆☆

IMPORTANT NOTICE TO ALL PRACTISING PHYSICIANS

The Secretary of the Board of Examiners for Nursing reports that to date only one person employed in a physician's office has applied for trained attendant certification under the waiver. A number of physicians employ as "office nurse" individuals with a variable amount of preparation. These individuals, heretofore, have not been required to be licensed but under the present law licensing is now required. Some of this group will be eligible for certification if they apply before the waiver expires.

The only professional endorsement required by law for trained attendant certification under the waiver is the signature of two physicians licensed to practice in Connecticut.

This is an important matter. Take care of it today!

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

New England Health Insurance

The Council at its December meeting authorized the acceptance of the invitation to The Connecticut State Medical Society to serve among the sponsors of the New England Health Institute that will be held in Hartford during the week of April 15, 1940. This is the first time the Institute has been held in Connecticut since 1929 and the preliminary program offers much of interest. There will be over 100 lectures and demonstrations covering all fields of public health. A part of the program has been assigned to The Connecticut State Medical Society and under the direction of Doctor Joseph H. Howard, chairman of the Society's Committee on Public Health, a program of discussion of the relationship of the private practitioner to public health will be presented. More than 1000 physicians and public health workers registered for the 1929 Institute and there is every reason to believe that this number will be exceeded in 1940. Members of the Society are invited to attend and announcements of the meeting will be sent to them.

* * * *

Mid-Winter Dinner

Invitations and reservations cards to the mid-winter dinner of the Society which will be held at the Hartford Club in Hartford on Thursday, January 25, will reach the members of the Society soon after the publication of this issue. Guest of the evening will be Doctor Morris Fishbein, the Editor of the Journal of the American Medical Association, who will speak on "American Medicine and the National Government." Tickets for the dinner will be $2.00; ladies and other guests are invited, and reservations should be made promptly.

* * * *

At The Annual Meeting

The Connecticut Occupational Therapy Society will again meet and have an exhibit at the Annual Meeting of the State Society in Hartford in May 1940. The Society is also pleased to welcome for the first time the Connecticut Association of Medical Record Librarians who will have their annual meeting with the Medical Society.

* * * *

Pneumonia Series Successful

The series of meetings discussing the therapeutics of pneumonia that have been arranged by the State Department of Health and The Connecticut State Medical Society are most successful. To date approximately one thousand physicians have heard the programs. Meetings yet to be held are:

January 3, 1940 — 10:00 A.M.
Meriden Medical Society
Samuel J. Goldberg, Attending Physician, Grace Hospital
Meriden Hospital

—

January 3, 1940 — 9:00 P.M.
Torrington Medical Society
Clarence L. Robbins, Assistant Attending Physician, New Haven Hospital
Charlotte Hungerford Hospital

—

January 26, 1940 — 8:00 P.M.
Manchester Medical Society
Francis G. Blake, Sterling Professor of Medicine, Yale Medical School, Physician-in-Chief, New Haven Hospital
Manchester Y.M.C.A.

—

March 5, 1940 — 8:30 P.M.
Bridgeport Medical Society
Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical School
University Club

* * * *

Final Directory Notice

The prepublication offer for the Medical Directory of New York, New Jersey and Connecticut will soon close. The prepublication price of the Directory is $3.00. After publication it will be $5.00. Orders with remittance should be sent to the Secretary's Office.

Connecticut Hospital Association

GREETINGS

A BRISTOL HOSPITAL PROBLEM

One of the many perplexing problems confronting our hospital is that of controlling visitors. The patient complains that his hospital day is made up of interruptions — nursing care, physical examinations, treatments, medications and *visitors.*

We solve part of the problem, by having a rest period from 1:15 to 2:15 every afternoon, for ward and private patients alike, and woe betide anyone breaking this rule. Patients are tucked into bed, shades drawn, and doors closed, and except in case of emergency, they have one undisturbed hour to themselves. It took weeks to enforce this rule, but now it has become an accepted fact.

Bristol factories, like a great many other factories, have a 3 P.M. to 11 P.M. shift for their workers, and these visitors are the ones who cause us the most trouble. Our ward visiting hours are from 2:30 to 3:30 in the afternoon, and 7 to 8 in the evening, hence, making it difficult for these workers to visit their loved ones. If we allow them to break our rule, and visit the patient in the morning, they interfere with the morning care and doctor's rounds. However, if we don't show consideration for their wishes, we offend both patient and visitor alike.

If we could only educate our hospital visitors to the fact that by curtailing visiting hours and protecting patients from too many visitors we were doing them a truly helpful service, we would go a long way toward solving our problem.

Perhaps some other hospital faced with the same condition may be willing to give us some helpful hints and tell us how they would handle the situation under similar circumstances.

(Ed.) Perhaps the attending physicians could help materially in improving this situation by cooperating with the hospital administration, at least to the extent of warning the patients against having too many visitors because of the possible retarding of a quicker convalescence.

THE GREENWICH HOSPITAL DEVELOPMENT PLANS

The Greenwich Hospital Association, organized under a special act of the legislature, was incorporated as a non-profit hospital in 1903.

A building now used by the Y.W.C.A. was opened in 1906 as a hospital and in 1918 the present building was built to accommodate 79 adults, 16 children, and 20 bassinets for infants.

For the immediate future, plans have been filed with the building department to add 12 additional semi-private beds, 4 rooms, and 4 children's beds, bringing the total capacity up to 135 beds.

In addition, plans are in preparation for a new hospital building to accommodate a full capacity of 175 and built in such a way that future demands will be cared for by three additions of 50 beds each. The present hospital will be converted into a nurses' home.

(Ed.) Since the receipt of this item from the Superintendent of Greenwich Hospital, we learn that a gift of $500,000 has been offered provided the Hospital raises an additional $750,000, this money to be used for the new building. We all offer our congratulations to Greenwich Hospital for this magnificent opportunity of fulfilling their hospital plans.

* * * *

TORRINGTON HAS AN ACTIVE WOMEN'S AUXILIARY

Secures 1,043 Members In Annual Enrollment

A total of 1,043 members — 43 more than the goal — were secured during the membership campaign of the Charlotte Hungerford hospital auxiliary, according to reports presented at a meeting at the nurses' home. The financial return was $1,178.

Nearly 150 members of the auxiliary, from Litchfield, Goshen, Harwinton, Cornwall, Bantam, Morris and Torrington attended the meeting, testifying to the increasing interest being shown in the work of the auxiliary in connection with the hospital.

Mrs. Charles E. Bennett, president, announced December 19 as the date for the next meeting. Plans for the Christmas party to be held at that time are being formulated by a committee of which Mrs. William Weitfield is chairman.

"Why does a hospital need an auxiliary?" This question is voiced often by those unfamiliar with the work of an auxiliary as well as the operation of the hospital.

In reply to this question a spokesman for the auxiliary today issued the following statement:

"Statistics show that patients pay only about one-half of the expense of their care, the other half being paid mostly from the endowment fund. Decreased interest rates from that fund for a number of years have made it increasingly difficult to meet this expense as well as to provide for the general maintainance of the hospital at the high standard necessary for the greatest comfort and well-being of its patients.

"Membership fees in the auxiliary go far in assisting in a financial way as do funds derived from other sources such as card parties and various other projects.

"Not the least is the assistance, on which no monetary value can be placed, that can be given by a group of interested women — sewing, making dressings, visiting patients, particularly those without friends or relatives, distributing flowers, books and magazines, and toys and games to children, and the many other activities outside the scope of the general nursing staff.

"There is a great need for this assistance to make the hospital entirely adequate in its relation to the community and the patient. This need can best be met by the woman's auxiliary."

REPORT OF THE SEMI-ANNUAL MEETING OF THE CONNECTICUT STATE HOSPITAL ASSOCIATION HELD NOVEMBER 17, 1939

The Annual Assembly of the Connecticut Hospital Association was held at the Norwalk General Hospital in Norwalk, on Friday, November 17, 1939.

Dr. Wilmar Allen, President, called the meeting to order at 11:15 A.M. There were about forty-five members present.

The minutes of the preceding Assembly, held May 25, 1939 were read by the Secretary and approved.

REPORT OF THE TRUSTEES

The Secretary then read a report of the activities of the Board of Trustees during the past six months as follows: A closer relationship has been established between the State Medical Society and our Association. A Joint Meeting of both organizations has been held, and the Trustees have arranged for the participation of our Association in the Connecticut State Medical Journal. The Trustees have also considered a public relations program and are waiting to hear the results of such a program now being conducted in Massachusetts. The Board of Trustees has met with the Committee on Hospitals of the Connecticut State Medical Society relative to certain phases of plans for hospital care. It also had the unpleasant duty of accepting the resignation of Mrs. Lucy A. Pollock as President of the Connecticut Hospital Association. The Trustees also have considered the names of applicants for membership in the State Association which will be presented at this meeting.

Miss Anna M. Griffin, Treasurer, reported:

Total Receipts	$2,978.55
Total Expenses	$2,890.76
Balance on hand	$ 574.19

and $500.00 bond of the American Hospital Association. The Treasurer's accounts were audited by Seward and Monde, and their report was read by Mr. Richard J. Hancock, Chairman of the Auditing Committee.

On motion duly made and passed. these two reports were accepted.

REPORT OF THE COUNCIL ON GOVERNMENT RELATIONS

The report of the Council on Government Relations was presented by Mr. Oliver H. Bartine, Chairman of the Council, and on motion was accepted. It was an exhaustive report of work accomplished by this most important committee. As we all know, those years when the legislature meets every organization must be most

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

active in meeting adverse legislation and in endeavoring to secure helpful legislation, and Mr. Bartine's committee did a most excellent piece of work during the last general assembly. He reported that twenty-three bills had been passed and fifty-nine had failed of passage, all of which had some effect upon some phase of hospital operation; and that in addition to these eighty-two bills, there were many others which had to be studied carefully in order to determine whether they in anyway affected the voluntary hospitals of the state. The bills which were passed and in which the hospitals were more or less interested were reported by Mr. Bartine as follows:

H. B. 269 (Ch. 30) Settlement. No inhabitant of one town shall gain settlement in another except after four years of residence with no expense to either the second town or the state. By addition of the phrase "or the state," settlement in the second town is made somewhat more difficult. Of importance chiefly in determining to which town the hospital must look for reimbursement for pauper cases.

H. B. 279 (Ch. 277) State health department may procure pneumonia serum and distribute it to municipalities for furnishing to poor persons at town's expense.

H. B. 332 (Ch. 174) Permits fiduciary holders of stock to vote at corporate meetings. Fiduciaries may give proxies but each proxy must be limited only to one meeting.

H. B. 485 (Ch. 321) Principal and income act. This provides for the division of receipts from and expenses of trust property between the life tenant and the remaindermen.

H. B. 606 (Ch. 355) Regulation of practice of nursing. Divides nurses into two categories, registered nurses and trained attendants. Prescribes 28-months course for the former and 12-month course for latter, plus examinations. Exempts student doctors and nurses from necessity of obtaining certificates. Remaining provisions of the Act are substantially the same as the existing Act.

H. B. 857 (Ch. 338) Medical service corporations. Any of the county or state medical associations or seven private individuals may incorporate medical service corporation to operate a plan whereby medical services may be rendered by a legally registered physician to subscribers of corporation. Provisions of contracts are specified in the Act. Rates must be approved by the insurance commissioner with whom copy of all contracts must be filed and who may investigate the corporation books. Property tax exempt.

H. B. 1406 (Ch. 125) Places burden of pleading and proving contributory negligence on the defendant in trials for damages for personal injuries. This will be of some benefit to a plaintiff in suits against a member hospital. Under the present law the burden is on the defendant only in death cases.

H. B. 1444 (Ch. 161) All corporations without capital stock must file corporate return in even years with secretary of state giving name and location of corporation, names and addresses of officers and persons to receive process. New Act contains a large number of provisions covering forfeiture of corporate franchise for failure to file these reports. (Inapplicable to specially chartered corporations.)

H. B. 1499 (Ch. 360) Practice of optometry. Optometry courses extended from three to four years. New Act states that no person except licensed optometrist shall operate optometrical office. Old Act provides that department stores might operate optometrical office under the supervision of licensed optometrist.

S. B. 57 (Ch. 150) Hospital service corporations. Corporations may be formed for the purpose of giving hospital service to subscribers. Form of contracts is provided for by the Act. Rates are to be approved by the insurance commissioner with whom annual reports are to be filed. Property of such corporations shall be tax exempt.

S. B. 167 (Ch. 364) Pure food, drug and cosmetic Act. This practically incorporates the whole Federal pure food and drug act into state law. The Act is too long to be summarized briefly, but in general follows the Federal act in regard to definition of adulteration and misbranding etc. very closely.

S. B. 186 (Ch. 228) This eliminates the old rule that trust funds could only be invested in "legal investments." New law provides that trust funds may be invested in certain real estate mortgages, savings accounts and any bonds or stocks or other securities selected by the trustee with the care of a prudent investor.

S. B. 319 (Ch. 202) Increases the maximum payments in workmen's compensation cases from $21 to $25. Provides payments in case of disfigurement and further provides that a waiver of physical defects shall not include susceptibility or recurrence of occupational disease.

S. B. 542 (Ch. 94) Physician's report of contagious diseases shall include names of children under 13 suffering from venereal disease, the names not having been required under the old statute.

S. B. 913 (Ch. 276) Minimum wage law. No actual minimum wages are set out in the law and it is said to apply only to "sweat shops".

The following are the bills which were brought to your attention at the beginning of the Session and which were passed by the General Assembly but are perhaps of no particular importance to the hospitals.

H. B. 464 (Special Act) Amending Section 3 of Charter of State Medical Society in regard to make-up of House of Delegates.

H. B. 598 (Ch. 201) Narcotic Act amendment re definition of "cannabis".

H. B. 609 (Ch. 294) Abolition of county health officer and substitution of state's attorney as prosecutor in cases involving illegal practice of medicine.

H. B. 1013 (Ch. 247) Definition of practice of natureopathy.

H. B. 1505 (Ch. 145) Creation of board to divide state into hospital districts for commitment to Middletown, Norwich and Newtown insane asylums.

S. B. 178 (Ch. 291) Support of patients at Newington Home for Crippled Children.

S. B. 179 (Ch. 10) Reports of children in county homes;

substitution of commissioner of welfare as proper authority.
S. B. 749 (Ch. 185) Regulation of employees' group insurance policies.

He also reported the bills in which the hospitals were interested that failed of passage as follows:

H. B. 180. Employee's right to choose doctor in compensation cases.
H. B. 186. Hospital Plan, Inc.
H. B. 272. Increased widow's aid allowance.
H. B. 290. Examination of food handlers for communicable disease.
H. B. 294. Serological tests for syphilis in pregnant women.
H. B. 516. Salaries of board of natureopathic examiners.
H. B. 533. Attorney's lien for services.
H. B. 614. Hospital rates for town, city, county and state patients.
H. B. 845. Incorporating College of Natureopathic Physicians.
H. B. 855. Commissions to agents of hospital service corporations.
H. B. 924. Attachment of wages for hospital claims.
H. B. 983. Working hours for female nurses.
H. B. 1009. Medical examining board.
H. B. 1017. Medical examinations.
H. B. 1019. Ambulance regulations.
H. B. 1025. Choice of physicians by hospital patients.
H. B. 1034. Nurses examining board.
H. B. 1254. Abolition of county tax.
H. B. 1296. Hospital charges in compensation cases.
H. B. 1313. Attorney's liens.
H. B. 1335. Hospitalization of old age assistance recipients.
H. B. 1373. Registration of alien employees.
H. B. 1416. Hospital's right of action against pauper's relatives.
H. B. 1417. Attachment of wages.
H. B. 1453. Discrimination in employment.
H. B. 1486. Practice of chiropractic.
H. B. 1487. State payment of public health nurses.
H. B. 1488. Board of dental technician examiners.
H. B. 1489. Distribution of antitoxin.
H. B. 1508. Payment by state for pauper cases.
S. B. 17. State wages and hours board.
S. B. 31. Payment of wage claims.
S. B. 33. Hours of labor on state projects.
S. B. 155. Commitment of indigent inebriates.
S. B. 166. Licensing of food, drug and cosmetic manufacturers.
S. B. 168. Board of examiners in physiotherapy.
S. B. 173. Changes in M.D. requirements.
S. B. 175. Examination of food handlers for communicable disease.
S. B. 177. Removal of paupers to town of settlement.
S. B. 290. Working hours of female nurses.
S. B. 298. Restrictions on practice of dentistry.
S. B. 304. Right of state to recover from pauper's relatives.
S. B. 305. Board of examiners for all professions except law.
S. B. 401. Taxation of Hartford Retreat.
S. B. 468. Reimbursement for treatment of auto accident victims.
S. B. 518. Seniority rights of employees.
S. B. 534. Relatives liable for pauper's support.
S. B. 537. Repeal of widow's aid laws.
S. B. 625. Nursing service bureau of New Haven.
S. B. 875. Medical care for old age assistance recipients.
S. B. 903. Night work of women and minors.
S. B. 904. Sunday labor.
S. B. 905. Time allowed for employee's meals.
S. B. 909. Wages and hours for women and children.
S. B. 910. Wages and hours.
S. B. 914. Employment of minors.
S. B. 931. Practice of osteopathy.
S. B. 934. Examination of handlers of food stuffs.
S. B. 946. Changes in settlement laws.

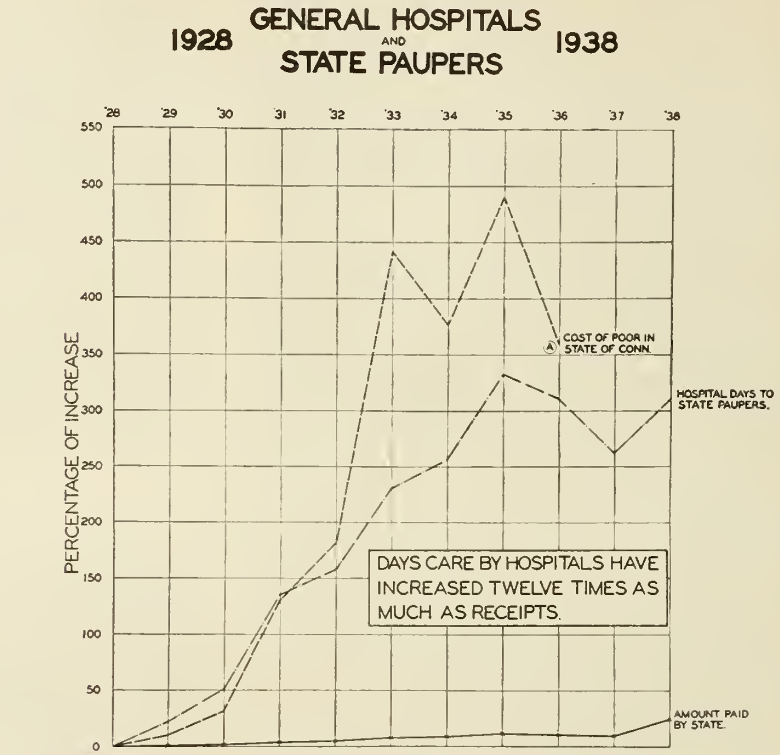
* * * *

Two bills which were of particular interest to the hospitals and failed of passage were: (1) The Automobile Responsibility Act, and (2) Bill No. 614 relative to state appropriations to hospitals. In this report Mr. Bartine stated that statistics presented by twenty-three of the thirty-six hospitals in Connecticut indicated they suffered an annual loss of about $90,000 in the care of state cases after crediting their accounts with the state grants; that these hospitals lost approximately $290,000 annually in the care of city and township patients for whom these governmental agencies are repsonsible, and about $60,000 in the care of automobile accident victims. House bill No. 614 was an attempt to correct the conditions relative to the losses sustained by voluntary hospitals in the care of state paupers. In appearing before the Committee on Humane Institutions and Public Welfare, the hospitals presented the chart on the following page.

This chart shows that the burden of the hospitals has increased out of all proportions to the allotments made by the State; in fact, about twelve times as fast. The Committee of the Hospital Association stated that certain hospitals having more specialists on their staff, more modern equipment, and more facilities receive more than their proportionate share of state paupers. A report by the State Welfare Department showed that one-third of the hospitals of the state do two-thirds of this work and receive less than one-half of the funds. The bill left the annual grants of all hospitals as at present but provided that a hospital should receive an average of $5.00 per day for the care of state cases and if its annual grant and the $8.00 per week paid by the state did not fully compensate the hospital up to $5.00 per day an additional amount should be paid by the state to bring the state payments up to the $5.00 per day level.

Following Mr. Bartine's report a special vote of appreciation by the State Hospital Association was tendered to him and to his committee.

(Ed.) Two important phases of this report should provoke thoughtful consideration in the minds of all our readers:—First, that the voluntary hospitals of Connecticut cannot long continue to furnish the type of service demanded by present day knowledge if they must assume an annual loss of $380,000 in the care of patients who are strictly the responsibility of the state government or subsidiaries of the state government, and particularly is this true when we realize that under the present economic conditions voluntary contributions are decreasing at the rate of 15 or 20% per year; nor can they afford to continue assuming the $60,000 annual loss in the care of automobile accident victims who are unable to make any payment for the hospital service rendered them. And secondly, because this is a problem which must affect the members of the medical profession and the peoples of every community, it would seem that we should combine our forces to secure adequate relief at the earliest possible moment.



TOTAL HOSPITAL DAYS TO STATE PAUPERS	18749	22905	28,296	44,166	48,347	62,005	66,874	81,223	77,036	66,105	76,884
PERCENT OF INCREASE	0	22	51	136	158	231	257	333	311	263	310
TOTAL AMOUNT PAID BY STATE	321,964	324,330	327,419	336,420	338,877	340,181	351,984	360,163	357,771	353,247	402,647
PERCENT OF INCREASE	0	1	2	4	5	8	9	12	11	10	25
TOTAL COST OF POOR IN STATE	2,157,662	2,368,756	2,857,341	4,993,653	8,015,829	11,691,904	10,280,562	12,723,538	9,897,319		
PERCENT OF INCREASE	0	10	32	131	272	442	376	490	359		

Ⓐ LATER FIGURES NOT AVAILABLE.
NOTE: AVERAGE STAY OF PATIENTS HAS DECLINED FROM 27 TO 16 6 DAYS
NOTE: FIGURES FURNISHED BY THE STATE DEPARTMENT OF PUBLIC WELFARE.

REPORT OF COMMITTEE ON UNIFORM COMPENSATION RATES

Report from the Committee on Uniform Compensation Rates was given by Dr. I. S. Geeter. After a short discussion of the work being carried on at the present time in conjunction with the Insurance Carriers Committee, this Committee was instructed to continue its work.

REPORT OF COMMITTEE ON NURSES EXAMINERS AND REGISTRATION

Dr. Buck, Chairman of the Advisory Committee to the State Board of Nurses Examiners and Registration, reported on the activities of this Committee. Two meetings have been held. The first meeting was held on June 28, 1939, and the objectives were: (1) to acquaint the members of this Committee with the activities and functions of the Board of Examiners and Registration of Nurses; (2) to acquaint members of the Committee with problems of administration of the law; (3) for Committee members to interpret work of this Board to their Association; (4) to study legislation that concerns care of the sick. The second meeting was concerned with the matter of licensing trained attendants. This was discussed at some length. Upon motion, this report was accepted.

Dr. Allen presented the visiting Delegate from the Connecticut State Medical Society, Dr. Bertram Lambert, who spoke briefly.

The meeting then adjourned for luncheon at 1:15 p.m.

The Assembly reconvened at 2:15 p.m.

Dr. Allen presided and introduced Miss Agnes K. Ohlson, guest speaker, who gave a talk on "The New State Nursing Act." A general discussion followed in which Miss Ohlson actively participated. It was agreed that it would be beneficial to the hospitals for the Advisory Committee members to work in close cooperation with the State Board of Nurses Examiners and Registration.

The Secretary read a letter from Dr. Creighton Barker, Executive Secretary of the Connecticut State Medical Society, inviting the Connecticut Hospital Association to hold its next annual meeting in conjunction with the State Medical Society on May 22, 1940, at the Hotel Bond, Hartford. Upon motion, it was moved to accept this invitation.

Mr. Sidney Davidson, member of the Editorial Board of the Connecticut State Medical Journal, representing the Connecticut Hospital Association, reported that joining with the Connecticut State Medical Society in publishing this Journal is a fine start in the betterment of relations between those active in the hospital field and the medical profession. The plan presents an excellent opportunity for the Hospital Association to give publicity to hospital operations, staff activities, needs, et cetera, and, at the same time, through well written articles, to present to others our thoughts in hospital affairs. All hospital members are urged to give their fullest cooperation and to prepare some material, either news items or articles, regarding hospitals and hospital services in the community. He stated further, that in order to make this venture successful, it will be necessary to have material from all of our hospitals and personal members.

Mr. W. Enos Cornett, representing the Connecticut Hospital Association in securing advertising for the Journal, reported in regard to the cost of advertising and on ways in which this Association could recoup some of the money to be spent on this Journal. He stated that he was sending questionnaires to the hospitals in order to determine the amount of supplies used, et cetera, and urged the hospitals to cooperate and assist by completing these forms as they would provide material which would be of benefit in the solicitation of advertising for the Journal from the various manufacturers.

On motion, these two reports were accepted.

The Secretary read a letter from the Hospital Association of Pennsylvania advising this Association that they were holding their next Annual Meeting on dates May 8-9-10, 1940. The Secretary was instructed to write them stating that our next Annual Meeting would be held on May 22, 1940, at the Hotel Bond, Hartford, Conn.

After further discussion in regard to the Report of the Board of Trustees, heretofore mentioned, on motion made by Mr. Hamilton, seconded and approved, it was VOTED to lay on the table without acceptance the Report of the Board of Trustees and that any action contained in their report shall not be communicated to any other organization as the official action of this Association.

Dr. Allen reported that the Hospital Insurance Policy Committee and the Advisory Committee to the State Board of Nurses Examiners and Registration, Special Committees appointed by the Board of Trustees, would continue their functions.

On motion, the President was empowered to appoint a Committee to Study Revision of Hospital Rates. This Committee is to compile rates charged by the various hospitals along the lines of the report rendered by Dr. Reek some time ago.

Dr. Allen reported on the work which has been done with regard to codification of the laws of the State of Connecticut applicable to hospitals. The printing of these laws was held in abeyance in order, that any changes by the legislature be included. Mr. Bartine reported that Mr. Arnow Thomas would be very glad to complete codification and bring up to date all statutes for hospitals, without charge. On motion, it was moved that Mr. Thomas be instructed to proceed with this work and that he be informed of the appreciation of this Association for his unlimited efforts in our behalf.

On motion duly made and approved, the Board of Trustees was authorized to study the matter of printing these laws, in loose-leaf book form, and to proceed with the work if, in their opinion, it does not exceed more than the hospital or this Association can afford to pay. Vote of the Assembly is to be sought if the price is questionable.

Dr. Allen stated that it was desirable to have as many as possible of the members of the Board of Directors, and others, of all hospitals join this Association. All members present were urged to cooperate in securing memberships.

The following applications were presented to the Assembly for acceptance:

Personal Active Members:

Edwin F. Saunders, Asst. Purchasing Agent, Greenwich Hospital.

William J. Ryan, Superintendent, Hartford Municipal Hospital.

Harry P. Kennedy, Vice-President, Grace Hospital, New Haven.

Dr. I. S. Geeter, Medical Director, New Britain Hospital.

Vera J. Meeker, Director of Nursing, New Britain Hospital.

Personal Associate member:

John C. Gardiner, Ridgefield

Associate Institutional member:

The Hospital Service Plan, Inc., Norwalk.

On motion duly made and passed, the Secretary was instructed to cast a ballot for each member by name. This the Secretary did and declared all members elected.

Dr. Mason, Chairman of the Nominating Committee, presented the following slate in the election of new officers for the year 1939-40.

Dr. Wilmar Allen — President
Miss Anna M. Griffin — Vice-President
Miss Helen T. Nivison — Treasurer
Mr. William B. Sweeney — Secretary
Mr. Oliver Bartine — Trustee for 2 years

Mr. Hamilton moved that nominations be closed and that the Secretary be instructed to cast one ballot for the slate as presented. The motion was seconded by Dr. Buck. Whereupon, Mr. Loase, acting as Chairman, put the Vote to the Assembly and received an affirmative vote on the slate as presented.

After considerable discussion, it was VOTED that the President appoint a committee to study the type, rates, and costs of those services furnished in the hospitals of this Association which can be considered joint services performed jointly by members of the medical profession and by the hospital organization, for which the hospital renders the complete charge to the patient.

Mr. Bartine praised Mr. Loase for his work as secretary during the past year and declared a vote of thanks was in order. Also, that appreciation be expressed for the valuable assistance given by various members, especially those of the Hartford Hospital.

On motion, a vote of thanks was extended to Mr. Brough for his kind hospitality and excellent dinner.

After discussion, on motion duly made and carried, it was VOTED that the Secretary be instructed:

(a) To secure from the hospitals of this Association the normal schedules of charges used for outpatient services (including special services, such as X-ray, physical therapy, etc.), and the schedules for rendering the same services to State Aided Patients, and

(b) To secure from the Association's attorney advice as to whether the State Law obligates hospitals, who accept State Aid Funds, to render such outpatient service at a per day rate of eight dollars per week.

A short discussion took place regarding the progress made in establishing an Eastern Institute.

Dr. Allen stated this was the last regular meeting until May 22, 1940. He urged all members to cooperate in making a success of the State Medical Journal.

There being no further business, the meeting adjourned at 5:06 P.M.

-The-
General Practitioner's Forum

Delayed shock, occurring 2 to 7 days following severe burns in children, is a serious complication. While these toxemias have been attributed to many things, one fact remains constant: — blood concentration plays an important role in the production of this condition. Many investigators have proved that this concentration, by its failure to maintain efficient circulation and oxygenation in the tissues, brings about tissue damage and the production of the toxic factor recently identified as guanidine. Supportive measures, transfusions and fluids have not been very successful in diluting the blood, and beyond a certain point have even been harmful.

The answer seems to be found in the use of intravenous injections of concentrated human serum of proper blood type. It is given in doses of 1 or 2 cc. per pound of body weight and repeated as necessary. Efficiency seems to be due to the concentrated colloids and proteins in the serum which actually draw fluid from the tissues and dilute the blood. This improves the circulation and oxygenation in the tissues, promotes diuresis and inhibits the formation of guanidine.

Reactions, mild in character, have been rare. Results in a well controlled series of cases have been excellent.

* * * *

Interpretation of intravenous pyelograms can be made much easier by the proper preparation of the patient. The following suggestions were made at a recent conference: no food and limited fluid intake for ten hours preceding examination; castor oil late at night; cleansing enema in the morning; subcutaneous injection of ½ cc. of the pituitary pressor hormone ½ hour before the test; examination, for minimum inconvenience to patient, at 9 A.M.

The little things you do for the patient's comfort build up good will. Take for example the application of adhesive tape. Although not new it is worth repeating.

Dry shave the part to be taped; clean with ether or benzine; apply a liberal coat of compound tincture of benzoin; let it dry thoroughly then put on the tape; final step is to dust the whole area with talcum powder in order to prevent the clothing from sticking.

The advantages are: the tape holds better; itching and the formation of tape acne are much reduced; removal is easier.

Another little thing, often overlooked, is the use of local anesthesia in suturing small lacerations. The belief, that the procedure being short the pain is minimal, is erroneous. A small pledget of cotton wet with a 2% solution of the anesthetic pressed into the wound and held there while you prepare your hands and suture material, is effective in a high percentage of cases. If this fails subcutaneous infiltration should be done.

* * * *

With the tools now available cutting a plaster cast is a hard tedious job, often painful to the patient. The following brainstorm is offered for what it is worth. It has worked successfully in a few cases, but it needs more trial to evaluate its usefulness.

The method uses a steel wire of about 10 to 12 B&S guage with a coarse thread on its middle two-thirds and looped ends, on the order of a Gigli saw. This is incorporated in the second layer of plaster along the axis of the intended cut and leaving the loops exposed. When the time comes to remove the plaster, Gigli handles or ordinary nails are slipped into the loops and the cast cut in jig-time. Two or more wires can be used for cuts at different angles. One point to be remembered, especially if you use a skin-tight plaster, cover the skin under the line of the intended cut with a strip of moleskin adhesive about 1½ inches wide. This protection is useful even when you use other methods of cutting casts. The experimental wires used were home-made, but it is possible that some manufacturer may be interested in producing them commercially.

T. P. R., M.D.

Our Neighbors

NEW JERSEY

On May 23, 1939, the Academy of Medicine of Northern New Jersey held a meeting in honor of Doctor Edward J. Ill on his eighty-fifth birthday. In recognition of Doctor Ill's part in upholding the ethical standards and advancing surgical practice — services rendered to the whole medical profession of New Jersey — as well as for the major part he played in the continued development of the Academy of Medicine of Northern New Jersey, the Council of the Academy resolved: "There shall be established from the general funds of the Academy the Dr. Edward J. Ill Award. The Award shall be given, at such times as the Council deems wise, to that doctor from Northern New Jersey who merits it for his extraordinary service as a physician and as a citizen." The achievements of Doctor Ill will go down in history and to him the medical profession may well point with the greatest pride.

* * * *

NEW YORK

Cash indemnity insurance for medical expense on a nonprofit and voluntary basis will soon be in operation in western, central and southeastern New York State. With the aid and cooperation of County Medical Societies three organizations, incorporated for the above purpose, have been given approval by the State Department of Social Welfare as provided by Article IX-C of the recently amended insurance laws of the State. These three organizations are Western New York Plan, Inc., Buffalo; Medical and Surgical Care, Inc., Utica; Medical Expense Fund of New York, Inc., Brooklyn. The details of the procedure of these plans, while similar in some regards, differ in others. All call for an agreement between the organization and the physicians who are willing to be listed. All set a yearly limit to the amount payable for various types of service. All provide for a contract with the policyholder. Premiums differ. The Council of the Medical Society of the State of New York has appointed a sub-committee of its Committee on Public Relations and Economics as a fact finding body ready to advise with County Societies and with such organizations on procedure as experience is gained.

The State Department of Health is reorganizing its cancer control program with the primary purpose of amplifying the resources available to practicing physicians throughout the state for the diagnosis and care of the disease. Public and professional education will be expanded under the new program. Tumor clinics in association with existing hospitals will be promoted. A cancer advisory committee has been appointed by the State Commissioner of Health to assist the Division of Cancer Control in outlining policies and to make available the benefit of their specialized knowledge and broad experience in various phases of clinical and laboratory cancer.

The "emergency flying squad" recently organized at Bellevue Hospital, New York City, had its first tryout on October 10. Thirty-seven interns, several nurses, six ambulances and one bus, all under the direction of three physicians, responded to a call to an explosion at 23rd Street and Lexington Avenue. In just one hour, without any hitch or confusion, all the emergency work was finished, all of the injured were on the way to hospitals and a cop who had been watching the proceedings was heard to say, "Sonny, it was smooth, damned smooth."

Health News, issued weekly by the New York Department of Health, is under fire in the editorial columns of the New York State Journal of Medicine for propagating the Health Commissioner's personal views at the expense of the medical profession. Commissioner Godfrey would seem to be in favor of political medicine and the use of the taxpayers' money for such propaganda is indeed highly questionable. At least, the issue is a controversial one and has no place in a weekly bulletin from any State Department of Health.

Doctor Henry J. Vier, the new president of the Westchester County Medical Society, in his inaugural address voices the criticism oft made that the Society makes little or no effort to welcome the new and younger members. Doctor Vier has endeavored to court discussion by the younger members on various actions taken in his Society. This situation is not peculiar to

Westchester. Medical societies are strong or weak depending on the interest taken by all the individual members.

The Medical and Pharmaceutical Societies of the County of New York are sponsoring a series of lectures for members of both professions on the subject of "Prescription Writing." These lectures are given at the Columbia University School of Pharmacy, 115 West 68th Street, New York City. On January 25 the title will be "Practical Prescription Writing" and the speakers will be Doctor Cary Eggleston of Cornell University Medical College and Doctor Leonard Piccoli of Fordham University College of Pharmacy. The lectures begin at 8:30 p.m. and are open to all interested in the subject.

* * * *

RHODE ISLAND

The new auditorium building at the Rhode Island State Hospital was recently dedicated to Doctor Arthur H. Harrington and named the "Arthur H. Harrington Assembly House." A memorial service was held at noon and after lunch dedicatory services were held. Eloquent tribute was paid to Doctor Harrington and the work for which he was responsible at the State Hospital.

* * * *

VERMONT

The Vermont State Medical Society is interested in assembling data contributing to a history of medicine in that State. At the annual meeting of the House of Delegates held at Burlington on October 4, a motion was carried placing $150 at the discretion of the Secretary of the Society to secure literature pertaining to early Vermont medical history.

The officers of the State Society elected for the ensuing year were: President, C. F. Ball, Rutland; President-Elect, A. M. Cram, Bridgewater; Vice-President, W. W. Angell, Randolph; Secretary, B. F. Cook, Rutland; Treasurer, David Marvin, Essex Junction; Auditor, T. S. Brown, Burlington. The Councilor for the second district appears to be none other than R. E. Seeley of Rutland whose son is at present serving an internship in the Hartford Hospital, Hartford, Conn. F. E. Farmer of St. Johnsbury was elecred the delegate to Connecticut.

Carrying out its plans to enlarge the teaching facilities of the University of Vermont College of Medicine by utilizing four more hospitals, two in Vermont, one in Springfield and one in Worcester, Massachusetts, (see page 699, December 1939, Journal), announcement has been made of additions to the faculty of several physicians from staffs of these same four hospitals.

☆☆

- NEWS -
from County Associations

Fairfield

At a combined meeting of the Board of Trustees and the Committee on Medical Economics of the Fairfield County Medical Association held on Tuesday, December 5th, the question of the National Physicians' Committee for the Extension of Medical Service was discussed.

Dr. Stringfield read a letter from Dr. Barker explaining his views on the subject and the members present discussed it with a great deal of interest. This motion was unanimously carried: "The Board of Trustees and the Economics Committee of the Fairfield County Medical Association, after investigation of the soundness of the principles of the National Physicians' Committee for the Extension of Medical Service, voted to recommend to the members of the profession, to lend their individual moral and financial support to the project."

It was further decided that the secretary of each local medical society in Fairfield County should call a special meeting of their local society to discuss this very urgent question before the first of the year, and that the National Physicians' Committee be asked to send each member of the Association one of their pamphlets, in order that they could acquaint themselves with the purpose of the organization. Each local Secretary is being sent a copy of the pamphlet in order that they may study it before calling a special meeting.

* * * *

Hartford

The Board of Directors of the County Medical Association has approved of a Times Radio Blood Donors' League and in so voting, expressed the opinion that doctors throughout the county might welcome a similar set up in their respective communities.

The following is a plan of operation worked out by a joint committee representing the Hospitals, Medical Information Bureau and Station WTHT. This Donors' League is now in operation and is designed for use in connection with the four public hospitals in Hartford only.

1. This League is an *emergency service* intended *solely* for patients who are positively unable to secure a necessary transfusion in *any other way*. Where there is ability to pay or where friends or relatives are able to supply the transfusions, this group will not function.
2. No call requesting a donor of a transfusion will be accepted except from a Hospital or attending Physician.
3. Two files are kept: One at the Radio Station and one at the Central Hartford Police Station. These files contain the name of blood donors with their blood types, and are filed according to the four types of blood, together with all information necessary for contacting the donors. Actual contacting of donors shall be through Station WTHT — not by physicians or hospitals direct.
4. In case of extreme emergency the Police Department will aid in transporting the donor to the stricken patient.
5. With a routine case where speed is not too essential, a taxi or other transportation should be provided for the donor.
6. Twenty four hour service is provided for and calls will be received at the Radio Station from 7 A.M. until 12 midnight — Tel. 7-6481—every day except on Sunday. On Sunday calls will be received from 8 A.M. until midnight. Calls will be accepted at the Police Station where a duplicate file is kept, from 12 o'clock midnight until 7 in the morning on week days, and until 8 on Sunday morning. The number is 2-4131.
7. Again we repeat — no calls will be accepted at the Radio Station or at the Police Station except from a Hospital or Attending Physician. The success of this Plan depends largely on how carefully it is used and safeguarded by physicians. Please be alert to prevent abuse of the generosity of these donors by selfish and unscrupulous persons.
8. Address or telephone all inquiries to Station WTHT — Tel. 7-6481.

The Board of Directors has also voted to have copies of the new By-Laws printed. Also there will be new application and endorsement forms. A committee of two, namely Doctor C. Brewster Brainard and the Secretary Doctor F. T. Oberg, were appointed for this undertaking. When available, copies will be given to members on application.

Doctor Charles W. O'Neil was recently made a fellow of the American Academy of Dermatology and Syphilology.

On November 20, 1939, Doctor John Scudder of the Presbyterian Hospital of New York City gave a paper illustrated with movies and featured by practical demonstrations. His subject was "Blood Studies in Shock as a Guide to Therapy." He pointed out the value of early hematocrit, specific gravity and protein estimations of the blood in shock and in conditions where shock might be more or less anticipated.

On December 4, 1939, Doctor Chester F. Keefer, Associate Professor of Medicine at Harvard Medical School, discussed "Modern Methods in the Treatment of Pneumonia." After considering pneumonia in a general way, he gave the indications for treatment, whether by serum or by sulfapyridine or by both, and gave in some detail the dosage and contraindications for sulfapyridine.

In the symposium on chronic arthritis appearing in the New York State Journal of Medicine, November 15, 1939, may be found an article on "The Use of Synovectomy in Chronic Arthritis" by Doctor Paul P. Swett of Bloomfield.

Collaborating with three other writers, Doctor Ralph M. Tovell of Hartford has an article in the Journal of the American Medical Association, November 18, 1939, on "Pentothal Sodium."

* * * *

Litchfield

Verdicts for the defendant, Doctor H. B. Hanchett, have been filed in the Superior Court by Judge Ernest A. Inglis. Damage suits resulted from an automobile accident occurring on June 11, 1939 on the Litchfield-Bantam road. The two plaintiffs, William H. Horwath and Raymond Michaelis, claimed damages of

$10,000. All principals in the action were injured in the accident.

At the annual meeting of the members of the American Hospital Association resident in Connecticut held at the Norwalk Hospital on November 17, Doctor Albert W. Buck, director of the Charlotte Hungerford Hospital, was named alternate delegate to the American Hospital Association. The delegate is Doctor Wilmar M. Allen of Hartford, who was elected President of the State Association.

In the memory of the founder of the Hospital, Uri T. Hungerford, the Seventeenth Annual Dinner was given by the corporators and the medical staff of the Charlotte Hungerford Hospital at the Conley Inn on Monday evening, December the 18th. This meeting was attended by approximately one hundred persons, including corporators, Board of Governors, members of the medical staff and friends of the Hospital. The program was as follows:

Invocation, by Rev. Vincent Murphy of the St. Francis Church, Torrington.

Introduction of the Toastmaster, William A. Gleeson, Esq. the by President of the Board of Governors, Francis H. Griffiths. Remarks, by Francis H. Griffiths, President of the Board of Governors.

Introduction of the Secretary of the Connecticut State Medical Society, Dr. Creighton Barker.

Address, by David R. Lyman, M.D., Director of the Gaylord Farms Sanitorium.

Benediction, by Rev. Bartram T. Anderson, Litchfield, Conn.

In a column "Read it or not" by Tomp, in the November 25 issue of the Torrington Register there appeared the following item:—"It's all in the viewpoint of course, but, happening to pick up a copy of the annual report of the Charlotte Hungerford Hospital last p.m., it made us feel just a wee bit uncomfortable to note that the chief of the surgical staff was "*pleased* to report there has been a very considerable increase in the activity of the surgical department during the past year," and that the head of the orthopedic department was "*pleased* to report that there has been a considerable increase in number of patients." The italics are ours.

During a recent campaign for membership, the Charlotte Hungerford Hospital Auxiliary obtained a total of 1043 members. The financial return was $1178. The meeting of this organization was held December 19 with Mrs. Charles E. Bennett presiding. To the question "Why does a hospital need an auxiliary?" a spokesman for the auxiliary issued the following statement, which appeared in a recent issue of the Torrington Register, "Statistics show that patients pay only about one-half of the expense of their care, the other half being paid mostly from the endowment fund. Decreased interest rates from that fund for a number of years have made it increasingly difficult to meet this expense as well as to provide for the general maintainance of the hospital at the high standard necessary for the greatest comfort and well-being of its patients.

"Membership fees in the auxiliary go far in assisting in a financial way as do funds derived from other sources such as card parties and various other projects.

"Not the least is the assistance, on which no monetary value can be placed, that can be given by a group of interested women — sewing, making dressings, visiting patients, particularly those without friends or relatives, distributing flowers, books and magazines, and toys and games to children, and the many other activities outside the scope of the general nursing staff.

"There is a great need for this assistance to make the hospital entirely adequate in its relation to the community and the patient. This need can best be met by the woman's auxiliary."

Doctor T. L. Thomson assumed his usual role as Santa Claus at the annual Children's Christmas Party given by the nurses at the Charlotte Hungerford Hospital on December 21 in the auditorium of the Memorial Home for Nurses. Complete outfits of clothing and various gifts and toys were given to sixteen underprivileged children. Refreshments were served.

* * * *

Middlesex

Doctor J. Edward Waldman, for the past several years a practicing physician in Higganum and a member of the junior attending staff at the Middlesex Hospital, leaves on January 1 for several months post graduate study in Boston, Mass. and Buffalo, N.Y. Doctor Waldman will take up the eye, ear, nose and throat specialty. His plans upon completion of his studies are indefinite. He has been a popular member of the younger group and his colleagues wish him well in his new work.

Doctor J. Henry Colomb, who until recently was clinical director at the Connecticut State Hospital in Middletown, has taken a position as assistant superintendent at the Mansfield School. Doctor Colomb was serving as Vice-President of the Central Medical Society this year. Doctor Charles Russman, for several years a staff member at the Hospital, has become clinical director.

The School of Nursing of the Connecticut State Hospital held its graduating exercises early in December. Doctor William M. Joyce of Middletown gave the principal address of the occasion. This is the last class that will receive its diplomas from the Hospital as the School is being discontinued.

Mr. Howard S. Pfirman, Superintendent of the Middlesex Hospital, held a meeting on December 12 with health officers and officials of county towns, the purpose being to expedite care of town patients ill with pneumonia. Mr. Pfirman is attempting to obviate any delay caused by question of financial responsibility to those patients needing anti-pneumococcic serum.

Doctor Louis O. LaBella recently was host to a group of eight physicians at a dinner held at the Monte Green Inn, Middletown. The evening was most thoroughly enjoyed by all those fortunate enough to attend. By unanimous vote Doctor LaBella was asked to be host again in the near future.

Doctor Norman E. Gissler has returned from an extensive hunting trip through the Carolinas. Stories of game bagged and almost bagged have reverberated through the halls of Middletown's public institutions for the past several days.

Doctor and Mrs. Louis Soreff of East Hampton are now occupying their beautiful new home recently completed on Main Street in East Hampton.

Doctor and Mrs. Peter F. Piasta recently purchased one of Middletown's fine homes on South Main Street and plan occupancy in the spring.

Doctor and Mrs. Harry S. Frank, who recently purchased a spacious house on Washington Street overlooking the Washington Green, are having the house completely rebuilt. They plan to make it their home in a few weeks.

At the December 11 meeting of the Central Medical Society, Doctors Sweet, Magnano, LaBella and Frank spoke on advances in their own specialities presented at the recent meeting of the American College of Surgeons. On December 20, Doctor Thomas Murdock of Meriden spoke under the auspices of the Connecticut State Medical Society and the Connecticut State Department of Health on the present day treatment of pneumonia. Both meetings were well attended.

The Middletown Board of Health has informed the Central Medical Society that the laboratory of the Middlesex Hospital will now be used as the public health laboratory and specimens need no longer be sent to the State Laboratory. The Board also voted that it wished at all times to cooperate with the local medical society and preferred discussions to take place across the conference table rather than through the public press.

Mr. Fred N. Smith, City Editor of the Middletown Press, spoke briefly before a board meeting of the Middlesex Hospital on December 13, at which time he explained the purposes of a proposed Blood Donors' League. The Board went on record as approving the formation of such a league in this section of the state.

Doctors Chase, Nelson and Joyce, all recently on enforced vacations through illness, have fully recovered and are again in active practice.

* * * *

New Haven

Doctor Herbert Thoms of New Haven presented a paper on "Roentgen Pelvimetry" before the Obstetrical Society of Philadelphia on November 2.

Doctor David R. Lyman of Wallingford delivered a memorial address on Doctor Hoyt E. Dearholt, former executive secretary of the Wisconsin Anti Tuberculosis Association, at the 31st annual meeting of the association held recently in Milwaukee.

Doctor Milton C. Winternitz of New Haven was the guest speaker at the regular meeting of the Main Line Branch of the Montgomery County Medical Society held at Bryn Mawr, Pennsylvania, on November 13. His subject was "Cardiovascular Renal Disease Relationships."

The Rhode Island Medical Journal, November 1939, contains an article by Doctor Paul W. Preu of New Haven entitled, "Bromide Intoxication."

SPECIAL NOTICES

ANNUAL CONGRESS ON INDUSTRIAL HEALTH

The second Annual Congress on Industrial Health, sponsored by the American Medical Association will be held Monday and Tuesday, Jan. 15 and 16, 1940, at the Palmer House, Chicago.

The program will be as follows:

OPENING SESSION, MONDAY MORNING, 9:45

Report of the Council on Industrial Health.
Stanley J. Seegar, M. D., Chairman, Milwaukee.

Vocational Rehabilitation in Relation to Medical Practice and Workmen's Compensation Procedure.
Terry C. Foster, U. S. Office of Education, Washington, D. C.

Industrial Psychiatry and Mental Hygiene.
Lydia G. Giberson, M.D., New York,

Adequate Nutrition for the Industrial Worker.
Lela E. Booher, Ph. D., U. S. Department of Agriculture, Washington, D. C.

MONDAY AFTERNOON, 2:15

Syphilis in Industry

Syphilis in Industry with Special Reference to Its Incidence and Relation to Trauma.
Earl D. Osborne, M.D., Professor of Dermatology and Syphilology, University of Buffalo School of Medicine, Buffalo.

Syphilis Case Finding in Industry.
Albert E. Russell, M.D., Surgeon in Charge, Office of Syphilis Control in Industry, U. S. Public Health Service, Chicago.

Integrating Syphilis Control Between the Industrial and the Private Practitioner.
Harold A. Vonachen, M.D., President, Central States Society of Industrial Medicine and Surgery, Peoria, Ill.

Syphilis and Employment.
Harvey Bartle, M.D., Chief Medical Examiner, Pennsylvania Railroad, Philadelphia.

MONDAY EVENING 6:30

An informal dinner and round table discussion, intended primarily for members of state and county medical society committees on industrial health, will be held. The subject matter for discussion will include problems of organization and plans for future activity.

TUESDAY MORNING, 9:30

Physical Examinations

Objectives of Health Examination and Their Industrial Applications.
McIver Woody, M.D., President, American Association of Industrial Physicians and Surgeons, New York.

The Private Practitioner and Industrial Physical Examinations.
Raymond Hussey, M.D., Chairman of Committee on Industrial Health, Medical and Chirurgical Faculty of the State of Maryland, Baltimore.

The Wisconsin Plan for Physical Examinations in Industry: The Point of View of the Industrial Commission.
Harry A. Nelson, Director, Workmen's Compensation, Industrial Commission of Wisconsin, Madison, Wis.

Scope and Methods of Industrial Physical Examinations of the Wisconsin Plan.
Paul A. Brehm, M.D., Chairman of the Medical Subcommittee on Physical Examinations in Industry, Industrial Commission of Wisconsin, Madison, Wis.

TUESDAY AFTERNOON, 2 O'CLOCK

Disability Evaluation

Hearing Loss—Estimation of Disability.
Austin Hayden, M.D., Chairman Consultants on Audiometers and Hearing Aids, Council on Physical Therapy, American Medical Association, Chicago.

Present Status of Estimating Disability from Visual Loss.
Harry S. Gradle, M.D., Chicago.

Are Uniform Standards of Disability Evaluation Practicable?
Earl D. McBride, M.D., Oklahoma City.

Critique of Disability Evaluation.
Henry H. Kessler, M.D., Newark, N.J.

WEDNESDAY, JANUARY 17

On the day following the Congress on Industrial Health, the Chicago Medical Society will conduct all day clinics illustrating practical problems in industrial medicine and traumatic surgery at St. Luke's Hospital in Chicago. These programs are under the direction of Drs. James A. Britton and Harry E. Mock respectively.

On the same day the Chicago Medical Society will conduct a dinner and evening meeting to be addressed by Dr. Vilray P. Blair, St. Louis, on "Treatment of Facial Deformities Caused by Injury."

* * * *

EXAMINATIONS
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The written examination and review of case histories (Part I) for Group B candidates will be held in the various cities of the United States and Canada on Saturday, January 6, 1940, at 2:00 P.M. Formal notice of the place of examination will be sent each candidate several weeks in advance of the examination date. No candidate will be admitted to examination whose examination fee has not been paid at the Secretary's Office. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held in June 1940. Receipt of Group B applications for the current examination (January 6, 1940) closed October 4, 1939.

The general oral and pathological examinations (PartII) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City N.J., on June 8, 9, 10, and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Application for admission to Group A, Part II, examinations must be on file in the Secretary's Office not later than March 15, 1940.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh6, Pennsylvania.

* * * *

THE AMERICAN BOARD OF OPHTHALMOLOGY

WRITTEN EXAMINATION, March 2nd, 1940, in various cities throughout the country.

THIS WILL BE THE ONLY WRITTEN EXAMINATION IN 1940.

All applications for this examination must be received before January 1st, 1940. All applicants must pass satisfactory written examination before being admitted to oral examination.

ORAL EXAMINATION: New York City, June 8th and 10th. Fall examination to be announced later.

CASE REPORT: Candidates planning to take June examination must file cases reports before March 1st.

For application blanks write AT ONCE to

Dr. John Green
6830 Waterman Ave.
St. Louis, Mo.

* * * *

MISSISSIPPI VALLEY MEDICAL SOCIETY 1940 ESSAY CONTEST

The Mississippi Valley Medical Society offers annually a cash prize of $100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society at Rock Island, Ill., Sept. 25, 26, 27, 1940, the society reserving the exclusive right to first publish the essay in its official publication — the MISSISSIPPI VALLEY MEDICAL JOURNAL (incorporating the RADIOLOGIC REVIEW). All contributions shall not exceed 5000 words, be typewritten in English in manuscript form, submitted in five copies and must be received not later than May 1, 1940. The winning essay of the 1939 contest appears in the Jan., 1940 issue of the MISSISSIPPI VALLEY MEDICAL JOURNAL (Quincy, Ill.) Further details may be secured from

Harold Swanberg, M.D., Secretary,
Mississippi Valley Medical Society
209-224 W.C.U. Building, Quincy, Ill.

* * * *

1940 MEETING MISSISSIPPI VALLEY MEDICAL SOCIETY, ROCK ISLAND, ILL.

The sixth annual meeting of the Mississippi Valley Medical Society will be held at the Hotel Fort Armstrong, Rock Island, Illinois, September 25, 26, 27, 1940. The meeting next fall will largely consist of practical instruction courses by well know clinicians and promises to be the most interesting in the Society's history.

CONNECTICUT STATE MEDICAL EXAMINING BOARD

LIST OF SUCCESSFUL APPLICANTS FOR LICENSURE AT THE NOVEMBER 1939 EXAMINATIONS

Applicants who appeared for written examinations, November 14 & 15

Fred W. Weile — 515 George St. New Haven, Conn.
Walter Grossmann — 157 Greenfield Street, Hartford
Silvio J. Caserta — 79 Beardsley Park Terrace, Bridgeport
Joseph B. Hanley — Todd Hollow, Terryville.
John Purney, Jr. — 730 Corbin Ave. New Britain
Arnold Davidson — 2035 Powell Ave., Bronx, N.Y.
Sidney E. Eisenberg — 73 Mason Drive, New Britain.
Robert J. Leonard — 40 Sharon St. Hartford
Marguerite D. Shepard — 9 Chelsea Square, N.Y.C.
Emil Szlemko — 157 Broad Street, New London
Edward V. Turner — New Haven Hospital, New Haven
Robert A. Hettig — New Haven Hospital, New Haven
Roger Fuller — Hartford Hospital, Hartford
James J. Sponzo — Municipal Hospital, Hartford
Henry W. Kraszewski — 126 Booth St., New Britain
Joseph A. Dugas — 104 Davenport St., Bridgeport
Gervase J. Connor — New Haven Hospital, New Haven

Applicants who appeared on the basis of credentials, November 28, 1939

John Hamilton Allan — 26 Second St. Stamford
Henry Bunting — 310 Cedar St. New Haven
George R. Cody — Main St. South Norwalk
William H. Curley — 70 Linden Ave., Bridgeport
Roger N. Fowler — 5 Library St. Mystic
Thomas Hale, Jr. — New Haven Hospital, New Haven
Curtiss Bronson Hickcox — 17 Cutler Knoll, Watertown
Gilbert R. Hubert — 485 Litchfield St., Torrington
Thomas J. Kirwin — 1 East 63 St. New York
William D. Mackay — 39 Edgewood Lane, Bronxville, N.Y
Moses Margolick — 151 Thames St., New London
Joyce S. Morris — 12 Sharof St. New London
Edward L. Mulford — Gaylord Farm Sanatorium, Wallingford
Raymond L. Osborne — 171 Washington St. Hartford
Mayo R. Purple — New Haven Hospital, New Haven
Jack D. Rosenbaum — New Haven Hospital, New Haven
Burnett Schaff — 200 East 8th St., Brooklyn, N.Y.
Sydney E. Sinclair — New Haven Hospital, New Haven
Arthur Bland Sullivan — 637 Park Road, West Hartford
Lewis Thorne — University Health, 109 College St. New Haven
Louis G. Welt — New Haven Hospital, New Haven

AMERICAN REGISTRY OF PHYSICAL THERAPY TECHNICIANS

The American Registry of Physical Therapy Technicians is supervised by a board appointed by the president of the American Congress of Physical Therapy. It has its rules for certification and for registration and its registrants are subject to a code of ethics. Connecticut has twenty such registered technicians.

Letters to the Editor

November 16, 1939

To the Editor of the Journal:—

A year ago we gave you a contract to carry our advertising in the Journal of the Connecticut State Medical Society. We did this for two reasons: first, that you were a good enough salesman to persuade us at the time that additional interest in our services would develop directly as a result of the advertising, making it a sound business deal, and second, that we ourselves felt, without persuasion from you, that we owed a debt of gratitude to Connecticut doctors and hospitals for the successful growth of our business, which debt we could partly repay by thus helping to support their official publication.

Now you ask us to renew our advertising contract and we pause to evaluate, if possible, the worth of continuing. We cannot point with certainty to case results from our previous messages in the Journal, although, generalizing, we have served more Connecticut doctors in the past year than ever before. Possibly you would like to claim this resulted from our support of the Journal, but it is tantalizing to try unsuccessfully to associate some slightly more specific evidence.

Not to keep you in suspense longer, we are going to continue our contract, as we still believe there are grounds for the slogan "It Pays to Advertise," and we wish to continue to support your Connecticut association and the Journal in every way possible. In evidence of our interest, we point out to you this phase of the problem, one which must always be a question mark to your advertisers, but which may not be too evident to you.

We know from examining copies of other medical journals, whose requests for advertising contracts we have refused, that you are to be congratulated on publishing one of the finest state journals in the country. But do all your advertisers know that? Why not boost your own stock a bit by occasional editorials addressed to advertisers calling attention to your circulation, to your aims and scope, to the advantages of Journal advertising, and to reassure them that the Connecticut doctors do take notice, and do reciprocate for their support, however intangible the results may seem.

Similar occasional editorials addressed to the doctors asking for their support of advertisers, would be bound to work to their Journal's advantage. Do you suppose most doctors stop to consider that any magazine or Journal can publish only a quantity and quality of material consistent with the fees from its advertising space? You know it, and your staff knows it, but possibly the reader members of the association would individually help to encourage advertising, and a still more successful journal, if they were reminded of this fact. Would an open comparison of Journal income and expense prove this point, and create some interest? Maybe a "case history" by you, in medical terminology, on each of your advertisers, with a diagnosis of their problem or product, treatment, and prognosis, might be amusing to advertisers and subscribers alike and create comment. Perhaps other advertisers and some doctors may have something of value to prescribe along these lines to the Journal's advantage. Possibly you might start a series of short articles written by the advertisers themselves, one appearing each month, in which they could express their own ideas on this same subject, and in that way make the appeal a little more varied and individual.

If you think any of our questions or suggestions have any merit, or might create any general interest to the advantage of the Journal, you have our permission to answer them through the pages of the Journal, instead of by personal letter.

Our renewal advertising contract is being mailed to you under separate cover.

The PROFESSIONAL EQUIPMENT Co.

RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.

TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

Yours, for a bigger and better Connecticut State Medical Journal,

The Professional Equipment Co.
New Haven, Conn.

* * * *

Trenton Trust Building
Trenton, Missouri

December 1, 1939

Secretary,
State Board of Health
Hartford, Connecticut

Dear Sir:

I am sending you copies of some of the many letters I have received from different oculists of the country. Also, a letter which I have written to several oculists regarding a man who is forging checks.

I wish you would print a copy of my personal letter to Dr. C. M. Sneed in your State Medical Journal. This man has been operating apparently for several years and I have determined to use every method at my command to intercept him. His description and method of operating will be found in the copy of my letter I have sent to the Eye, Ear, Nose and Throat Monthly, American Medical Journal and to the State Medical Journals of several states.

I would be pleased to receive a copy of your Journal when this is printed or you may send it to the Sheriff of Grundy County, Trenton, Missouri.

Please find enclosed postage for the issue of this Journal.

Thanking you, I am

Very truly yours,
Herbert C. Kimberlin, M.D.

September 27, 1939

Dr. C. M. Sneed
Columbia, Missouri

Dear Doctor:

I am writing you regarding a man who is running around through the country buying glasses especially from Oculists, usually giving a check to the amount of $30.00. This man tries to simulate a farmer and he usually has a notation on the check for corn, cow, hogs, etc. The name on the check to him is no doubt forged and there is no doubt his indorsement on the back of the check is forged. The man is about 49 years old, about five feet nine or ten inches tall, weighs about 155 pounds, light sandy hair, blue eyes, smooth shaven with a ruddy complexion.

Should this man come into your office making an attempt to cash such check as the above description, unless proven to be absolutely authentic, please notify the Sheriff of Nodaway County, Maryville, Missouri, or the Sheriff of Grundy County, Trenton, Missouri.

He usually signs his name on the back of the check in a very rough, but plainly legible hand and signs it W. C. Curran, and he usually wishes the difference between the amount of the check and the price of the glasses in cash, but does not call for the glasses. Should he sign his name and such a check be presented to you, please have the sheriff to intercept him.

Should you have any information regarding a man of his description passing checks of the above description, please inform the sheriffs above named, Dr. R. C. Pearson, Maryville, Missouri, or myself.

Thanking you, I am

Very truly yours
Herbert C. Kimberlin, M.D.

P.S. Please call attention to any other OLAR men which might be located in your city.

I sent a copy of this letter to many Oculists throughout the States of Iowa and Missouri.

Herbert C. Kimberlin, M.D.

December 8, 1939

Stanley H. Osborn, M.D.
Commissioner of Health
Hartford, Connecticut.

Dear Doctor:—

In reply to your recent letter requesting information as to an imposter circulating among the oculists, I am certain this man was treated in my office on June 3, 1938.

The method employed was exactly the same as used in the West and the address given was G. C. Marshall, R.F.D. No. 1, Rockville, Connecticut. He presented a check for $30.00, which my secretary refused to cash. All statements forwarded to that address were returned with notation "not known." I am enclosing herewith, copies of letters with description and other data that agrees with our experience. His presbyopia corresponds to his age — add plus 2.

I feel it should be publicized in your frequent bulletins, thus covering the entire state.

Yours sincerely,
William F. Reardon, M.D.

• OBITUARIES •

JAMES EDWARD MURPHY, M.D.

1878-1939

On Hallowe'en, 1939, the spirit of James Edward Murphy, of Hartford, Connecticut, passed on, leaving his environment the poorer for his departure, and leaving the rest of the "comedians" (as he facetiously called his confreres) to "carry on."

Born April 26, 1878, in Philadelphia, into a large family, he early learned tolerance and consideration of the other fellow's troubles. This was a life-long character-trait. In adolescence he was an altar-boy, and only a few close friends knew how devoutly religious he remained throughout his life.

After graduation in 1907 from Medico-Chirurgical College, now incorporated in the University of Pennsylvania, followed by a strenuous interneship, pulmonary tuberculosis necessitated a period of "cure," during which he learned personally the value of optimism and good-cheer. After he was well again, he radiated those qualities toward pulmonary invalids in practice the remainder of his life.

Although instinctively gregarious and loved by his friends and co-workers in the medical and nursing professions, he nevertheless chose to remain in bachelorhood. For more than twenty-five years he lived and worked at Wildwood Sanatorium. If "every institution is the lengthening shadow of a man," Wildwood was "Jimmie' Murphy (as he was affectionately known). Death came to him on the 26th anniversary of his arrival at Wildwood. But now, although both he and Wildwood are gone, a host of patients remain to sing his praises and mourn his loss. Only the alumni of Wildwood, the poor of Hartford, God, and Jimmie Murphy will ever know how much of himself he gave to them without renumeration. From a great host his only compensations were love, loyalty, friendship and respect. The high, the low, the wealthy and the less fortunate honored him at his funeral service in Hartford, before his body left for interment in his birthplace.

Although his counsel in his specialty of thoracic medicine will be missed in the local hospitals and courts, as well as his presence at State and National medical conventions, "Jimmie" Murphy will be best remembered for his good fellowship, rare good humor and generosity.

Ralph deB. Clarke, M.D.

• Quarto Notes •

ELECTROCARDIOGRAPHIC PATTERNS

by

Arlie R. Barnes, M.D.,
Mayo Clinic, Rochester, Minn.

195 pages 95 figures $5.00
Springfield, Ill. Charles C. Thomas 1939

This is an excellently written book, which, as the author suggests in his introduction, portrays the diagnostic and clinical significance of electrocardiographic changes in certain cardiac diseases. It is a development of which Whittens and Barnes hoped in 1928 to be able to correlate Electrocardiographic Changes with specific pathologic conditions in the heart.

The book is based on extensive experience, has numerous electrocardiograph records of the sujbects under discussion and an excellent bibliography.

It considers the relation of the distribution of the coronary artery to acute myocardial infraction; the various electrocardiographic changes in acute myocardial infarction, anterior, posterior, left and right heart, with the healing stages and clinical history; ventricular strain of the left and right heart (acute cor pulmonale); changes in pericarditis of the different types — purulent, chronic constrictive, rheumatic, etc., allowing proper treatment often only on account of the diagnostic aid given; changes due to metabolic disorders, disturbances of nutrition and common drugs; usefulness of the various precordial leads and their supplementation of the standard leads; finally, tables of summary of standard electrocardiograms and precordial leads of normal adults, male and female, maximal and minimal measurements of the different deflections.

The author has left no doubt that electrocardiograms can be of great diagnostic and prognostic value, often corroborating clinical impressions. Frequently, they may be of crucial diagnostic importance. On the other hand, Dr. Barnes has acknowledged frankly that in many instances electrocardiographic patterns are atypical or absent, and, in many instances of cardiac disease, no electrocardiographic changes are known.

The book is very helpful as a reference for those reading electrocardiograms.

J. A. Wentworth

LIBRARY

TEXTBOOK OF NERVOUS DISEASES

by

Bing and Haymaker

838 pages	Fifth Edition	$10.00
St. Louis	The C. V. Mosby Co.	1939

Dr. Robert Bing, Professor of Neurology, University of Basel, Switzerland, has created a text-book in Neurology which has been (this being the 5th Edition) and will always be a standard work. The present volume will be up to-date for some time to come as it already embraces new subjects which have appeared in current medical journals.

The translation from the German by Dr. Webb Haymaker of the University of California leaves nothing to be desired in its freely flowing, not too technical language. There is no suspicion that it is a translation.

The chapter plan is somewhat different. The exposé of symptoms and syndromes begins with the peripheral nerves, elaborates on disturbances of conductivity and the simple etiologic factors involved in the neuritides, and gradually brings the reader to the more complicated cranial nerve abnormalities. The elaboration of the symptomatology and treatment is modern, clear and intensely practical. It comes from a wealth of personal observations and is not too dogmatic. From the periphery one is lead to spinal and brain conditions with good illustrations, both photographic and schematic.

The section on Dyskinesias is most helpful because of its clarity and conciseness. The Progressive Muscular Atrophies, the Degenerative Diseases of the Neurons, the various Spinal Syndromes are nicely grouped together, which is an advantage in the confusing and closely related symptom pictures which they present. The tables covering practical anatomical considerations of group innervations and differential diagnoses save a great deal of detail reading.

As is true with all "Continental" authors, Syphilis of the Central Nervous System as described by Dr. Bing does not lack for diagnostic minutiae and criteria. This is also true of the differential diagnosis and therapy. The discussion of Acute Infections and Intoxications is helpful because of valuable therapeutic suggestions contained there-in. However, the intoxications are possibly somewhat scantily treated in view of the controversial medico-legal aspect which such conditions especially entail. It is surprising, though, how much important data is covered in a comparatively short space.

The chapters on Intracranial Pathology Tumors, Abscesses and Vascular Syndromes should be of value to the general practitioner as well as to the specialist. Circulatory Brain Changes include brain trauma, concerning which one would wish that the author had commented more extensively. However, this seems to have been left to the particularly complete and large bibliography on this subject.

The Malformations and Congenital Defects, the Cerebral Degenerations and Scleroses, are completely enumerated and classically described. Too much space is not given to these individually as, on the whole, they are not amenable to therapy. The interest is mainly diagnostic.

The major syndromes in endocrinology are discussed in a concise way and there is an evident conservatism relative to therapy and rightly so as, after all, it is in a stage of transition, nevertheless, it is replete with very late scientifically grounded data. In the 100 pages alloted to the Psychoneuroses and allied functional states by Dr. Bing one could not expect a complete and detailed elucidation of the various sub-headings, however, his happy faculty of saying much in few words, and that clearly and plainly is a commendable feature of this all-inclusive volume. Therapy in this field includes some good old time prescriptions, which, alas, are all too infrequently resorted to in this day of barbiturates and their highly priced "relatives." As a matter of fact therapeutic advice is one of the high lights of this work.

The Autonomic Nervous System is more completely treated and the pharmicologic studies described serve as fundamentals for a better future understanding of so called functional disorders. The subject of Convulsive Disorders furnishes new food for diagnostic thought and for treatment. The same may be said as regards the chapter given to the symptom "Headache."

The bibliography is extensive, up-to-date and well placed at the end of each chapter and all foreign titles are translated for the reader's convenience. The foot-notes and quotations are well chosen and very instructive.

This the 5th Edition of Bing (and Haymaker), should have its niche on the shelves of every medical library, whether of student, practitioner or specialist.

A. Gosselin.

⁂

LABORATORY MANUAL OF THE MASSACHUSETTS GENERAL HOSPITAL

by

Francis T. Hunter

119 pages	Third Edition	$1.75
Philadelphia	Lee & Febiger	1939

This pocket manual in its previous editions has been a constant companion of numerous interns. The third edition, largely rewritten, by the careful selection of material, the clear and concise manner of presentation will undoubtedly fill a similar place with present interns and older physicians. A practical manual with a useful appendix that can be sincerely recommended.

R. E. Kendall

The PROFESSIONAL EQUIPMENT Co. X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS. TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

PERIPHERAL VASCULAR DISEASES

DIAGNOSIS AND TREATMENT

by

William S. Collens, B.S., M.D.
Metabolist, Chief of the Clinic for Peripheral Vascular Disease, Chief of the Diabetic Clinic, Israel Zion Hospital, Brooklyn.
and
Nathan D. Wilensky, M.D.
Assistant in Clinic for Peripheral Vascular Disease, Assistant in Diabetic Clinic, Israel Zion Hospital.

243 Pages $4.50
Springfield, Illinois Charles C. Thomas 1939

Peripheral Vascular Diseases, their diagnosis and treatment by Drs. Collens and Wilensky has indeed been a pleasure to review. As one reads this book, there is constantly felt a plea by the authors for earlier diagnosis and conservatism.

Realizing that medicine and surgery today are based on a clearer conception of fundamentals, the authors immediately acquaint the reader with the anatomy and physiology of arteries, arterioles, capillaries, venules, veins and the role played by the involuntary nervous system in peripheral circulatory function. Of special interest in this chapter are the illustrations concerning 1. the capillary surrounded by an outer network of contractile elements, 2. the effect of mechanical pressure and colloid osmotic pressure on the flow of fluid through the wall of the capillary, 3. the arteriovenous anastomoses known as Sucquet-Hoyer canals for the dissipation of heat, and 4. the fact that arteries to the extremities derive their nerve supply from adjacent peripheral spinal nerves. Having thus laid the foundation by this anatomical and physiological study, the tests used for examining the extremities are next described. But under no circumstances should these special tests be done without first a complete physical examintion. Emphasis is laid on the value of inspection to note the color and the condition of the skin. the appearance of the nails, and the presence of skin lesions and phlebitis. Palpation of the extremities for temperature variation from functional or inflammatory causes is emphasized and the observance of the presence or absence of the peripheral arteries is also stressed. Many special tests such as x-ray with or without intravenous radio opaque substances, Buerger Test, reactive hyperemia test, oscillometry, skin temperature tests, walking test, etc., are given impartial consideration. "The Venous Filling Time Test" described by the authors is mentioned as being of special value and can be performed in conjunction with the Buerger Test. They fail, however, to mention the fact that this test is of no value when varicose veins are present.

The symptoms and signs of interference with arterial flow, whether acute or chronic, are next considered and, whereas nothing new is set forth, nevertheless, a great deal of valuable information is summed up in this chapter and is well worth reviewing. The chapters on peripheral vascular sclerosis, thrombo angiitis obliterans, and the Raynaud phenomena are complete in every detail. They contain only the important facts concerning these diseases gleaned from the literature and the authors' experiences.

In the treatment of vascular conditions where there is arterial impairment, one is concerned with increasing the flow of blood through an extremity. This brings up many problems of how to create the maximum state of vasodilatation and how to develop an adequate collateral circulation. Every type of treatment worthy of mention, whether physical, medical or surgical is considered and the reasons for their acceptance given. The most outstanding procedures mentioned are the Smithwick cervical sympathectomy and the Intermittent Venous Occlusion treatment with or without diathermy or short wave. It would seem that these authors have developed a procedure of great value by their Intermittent Venous Compression, for not only can it be used as a means of controlling and treating thrombo angiitis obliterans but it is excellent for releasing vasospasm. Intermittent Venous Compression, with or without diathermy or short wave, is also highly recommended in the treatment of long standing varicose ulcers and in cases of embolus over 10 hours duration. In both these conditions the authors have achieved striking results.

Inasmuch as a reviewer can only touch on the high points of a book, those desiring a more complete knowledge of the diagnosis and treatment of vascular disorders are urged to read this. It is the best book on this subject I have seen.

W. D. Scudder

CANCER OF THE LARYNX

by

Chevalier Jackson, M.D., ScD., LL.D., F.A.C.S.
Chevalier L. Jackson, A.B., M.D., M. Sc. (Med), F.A.C.S.

189 Illustrations 5 Colored Plates
Philadelphia W. B. Saunders Company 1939

In their usual clear concise manner the authors present an excellent treatise on cancer of the larynx.

The book is divided into three parts. Part I deals almost entirely with squamous cell cancer which includes approximately 90% of laryngeal cancers. The authors stress the importance of direct laryngeal examination and early biopsy. The selection of type of treatment for the particular case is discussed, and the technique of the various operative procedures is given in detail. Prognosis, operative mortality, and life expectancy are considered. The future of laryngectomized individuals and the mechanism of articulate speech in these patients are described. One chapter is devoted to treatment by irradiation, and the final chapter to palliative methods. Stripped as it is in essential details, Part I is an invaluable reference for the clinician in search of promptly available help.

Part II gives a rather detailed presentation of malignant growths other than squamous celled cancer, borderline tumors, and pre-cancerous conditions. Clinical data from the authors' records are submitted, showing that approximately 80% of laryngeal cancers are curable. In the final chapters the incidence, etiology and prophylaxis of cancer are considered. In Parts I and II colored plates illustrating various laryngeal conditions add to the clarity of descriptions.

Part III is entirely historical. While the data must of necessity be incomplete, the authors have traced the progress of the recognition and treatment of cancer of the larynx during more than a century. Chronologic data bearing on laryngofissure, laryngeal biopsy, and laryngectomy are given with the names of the men who have taken such an important part in the development of the treatment of this disease. In discussing the artificial larynx the authors state that more than 75% of their laryngectomized patients have developed a satisfactory voice and require no artificial aid. The earlier development of the artificial larynx, its use, and its recent modifications to meet the changes in laryngeal surgery are given. The chapter dealing with the history of irradiation gives the conflicting views on the results of radium and X-ray during the early years of its use in the larynx and traces the development of this type of therapy up to the present divided dosage method which gives satisfactory results in selected cases.

J. E. Davis

☆☆

THE VITAMINS

A Symposium Arranged Under the Auspices of the Council on Pharmacy and Chemistry and the Council on Foods of the American Medical Association.

637 pages
Chicago American Medical Association 1939

About twenty years ago our knowledge of the vitamins was as simple as A.B.C. Today, not only is the alphabet nearly exhausted but many of the so-called simple vitamins are known to be quite complex. The B vitamin, for instance, is known to contain at least four, and the D vitamin at least ten different components. To the average practitioner who finds it difficult to keep abreast of the vast, and sometimes conflicting, literature and who at the same time is not content to rely wholly on the detail men for his medical education, this volume is recommended.

This book is a digest of all the important experimental work. There are separate chapters on the chemistry, pathology, and therapeutics of each of the known vitamins written by men who know. Indeed the array of talent selected to write the volume should be enough of a recommendation.

To most of us it is a little late in life to try to master the complex chemical formulae, but it is essential, however, for us to know the symptoms and treatment of avitaminosis, for regardless of the branch of medicine we practice-internal medicine, pediatrics, obstetrics, dermatology, neurology, or surgery-we are liable to encounter some serious vitamin problem that can be very simply rectified.

The book is also intended for the research student, who will find an adequate bibliography in the footnotes to each chapter.

The whole subject has been made very interesting, and as concise as the material warrants. It is therefore easy to read.

E. Caulfield

PSYCHOBIOLOGY AND PSYCHIATRY

by

Wendell Muncie, M.D.
Associate Professor of Psychiatry,
Johns Hopkins University

739 Pages First Edition $8.00
St. Louis The C. V. Mosby Company 1939

Dr. Muncie has followed the Student's Personality Study, as utilized in teaching Psychobiology to students at Johns Hopkins, to produce a rather unique volume in the field of Psychiatry; namely, one which gives the reader the feeling of following an unusually connected sequence of expositions held together by a "plot." This makes the reading of the book far more enjoyable and facile than is usual with such a text. As is to be expected, emphasis throughout is placed upon the consideration of the functioning organism as a whole, repeatedly refuting the dualistic concepts of other physcological schools which separate "mind" from "body." This is, of course, in keeping with the entire general trend in psychiatric thinking, and the more so since the psychobiologic approach gives recognition to various schools and techniques as tools for furthering the understanding of the entire individual in his environment.

Throughout the book there is a studious effort to be all inclusive of the innumerable factors which contribute to the psychiatric picture. All methods of examination, not excluding the laboratory, are to be considered as integral parts of the routine survey. All the history, from genealogy to the present time, is included.

A new grouping of the various types of psychiatric reactions ("Holergasias," as named by the Psychobiologists) is found in which the conditions are placed together on the basis of the reaction seen to a much greater extent than upon the possible relationship between apparently unlike reactions. etiologically related. One misses, for example, emphasis upon the relation between the manic and the depressed phases of Manic-Depressive Psychosis.

There is, as compared with other teachings, a distinct under-emphasis on ultimate etiology. The development of the psychosis is depicted chronologically, showing the various stages of increasing tension due to progressive failure to adjust to the total environment, but one is conscious of wanting to know "why?" this failure occurred. The cases used to illustrate the various psychiatric conditions are well presented, but in the discussion which follows each, this "why?" recurs only too frequently.

This apparent lack is due to the Psychobiologists' determination to restrict themselves to only that which can be demonstrated clearly, and to avoid the field of speculation. Perhaps this is just as well, in a field where speculation has from time to time run rife. But to the reader it leaves some feeling of dissatisfaction. It may be that this feeling of dissatisfaction is their aim, in that such a feeling may serve as a stimulus toward further research to make clearer those unknown portions of man's functioning as a whole.

In the final portion of the book, Dr. Muncie has included an interesting compilation of the historical development of man's thoughts in regard to the psychopathological conditions. By the use of parallel columns he has made it possible to compare chronologically related ideas of different investigators with remarkable ease. True, this resumé is exceedingly abbreviated yet gives a quick survey which to those not yet familiar with the voluminous literature on the subject will give great value in orienting themselves in the field.

Many may be wary of this book because of its size. However, after completion one feels definitely that sections which receive relatively few pages could themselves easily be extended to full-volume size. It is to be hoped that the Psychobiologists will, as further data is accumulated, amplify and round out their concepts until that time when the questions which arise in the mind of the reader will all be answered.

C. W. Stephenson

☆☆

REPRINT PRICES

The following price list of reprints has been formulated from estimated prices furnished by our printer. These prices include a cover when necessary to make the number of pages an even one. Quantity prices not included will be furnished on request. If two or more halftones are used and the article printed on coated stock paper there will be an additional charge. The above prices are not final but are furnished our readers as estimates until experience shall enable us to publish net prices.

4 pages	
100 copies	$ 9.75
200 copies	11.25
300 copies	12.60
400 copies	13.75
500 copies	14.95
1000 copies	16.90
8 pages	
100 copies	12.75
200 copies	14.65
300 copies	16.50
400 copies	18.50
500 copies	20.25
1000 copies	25.50
16 pages	
100 copies	20.50
200 copies	24.50
300 copies	27.60
400 copies	30.35
500 copies	32.50
1000 copies	37.50

SOBISMINOL MASS AND SOBISMINOL SOLUTION SQUIBB NOW AVAILABLE

Reported as a new forward step in the treatment of syphilis, Sobisminol, the new A.M.A. Council Accepted spirocheticide is now available under the Squibb label in two dosage forms—Sobisminol Mass for oral use, and Sobisminol Solution for intra-muscular injection.

Given orally, Sobisminol Mass appears to have an antisyphilitic action comparable to that produced by Sobisminol Solution and other soluble compounds of bismuth administered parenterally. It has been given daily for periods of many months without producing cumulative toxic effects. It can be used wherever bismuth therapy is indicated in the treatment of syphilis, including use with one of the arsenicals or in alternate courses with arsenicals, according to the preference of the clinician.

Sobisminol preparations contain a complex organic bismuth compound resulting from the interaction of sodium bismuthate, tri-isopropanolamine and propylene glycol. Both Sobisminol Mass, and Sobisminol Solution, have been subjected to extensive pharmacologic and clinical studies which indicate that these products have a wide margin of safety, that they are promptly absorbed, and that bismuth is excreted at such rates and in such quantities as to indicate that while there is little accumulation of bismuth, the quantities retained are adequate for sustained systemic anti-syphilitic effect.

Sobisminol Mass is supplied in capsules for oral administration, containing 0.75 Gm. Sobisminol Mass, representing 150 mg. bismuth equivalent. The capsules are supplied in packages of 100 and 1,000 capsules. The average optimum adult dose is 2 capsules three times daily.

Sobisminol Solution for intramuscular administration is offered in three types of containers:

2 cc. ampuls in boxes of 12 and 100.
1 cc. ampuls in boxes of 12.
50 cc. bottles

Each cc. of solution represents 20 mg. of bismuth. The average adult dose is 2 cc. twice weekly.

SHOULD THERE BE FEDERAL DEPARTMENT TO AID THE STATES IN HEALTH WORK?*

Walter F. Donaldson, M. D.,**
Pittsburgh, Pa.

My thirty-five years' experience in the private practice of medicine, seasoned with dispensary and hospital connections, leads me definitely to favor the minimization of governmental bureaucratic influences over the delivery of sickness services. This naturally leads me into the ranks of observers and commentators who favor economy in the administrative provisions of essential public health services, whether they be Federal or state in origin.

Every accepted public health procedure in effect today sprang from a distinctly localized experience and undoubtedly the unsolved phases in the ultimate provision of adequate medical care should in most instances be left to the properly stimulated evolutionary experiences of the citizens and the medical profession of local communities. They alone know and understand their varied requirements. Such endeavors should receive the most sympathetic support from the Government in every legitimate way that is free from bureaucratic control.

Public health and medical service suffer and deteriorate through the application of regimented and governmentally-controlled methods of medical practice. European experience has demonstrated that experiments in political medicine are dangerous and give rise to far-reaching evils which are much worse than those allegedly justifying the experiment.

One must indeed be possessed of a childlike simplicity to believe that in distributing large sums of money (Federal) to voluntary institutions the determining consideration would be the institution's needs and their scientific efficiency.

Regimentation in the beneficent guise commonly advocated by zealous worshippers of social objectives will follow the requisite extension of Federal bureaus into the health departments of our sovereign states. This menace of self-reliance justifies close scrutiny of legislation allegedly applicable to the solution of an existing national health program.

I believe that the currently published platform of the American Medical Association is more worthy of adoption than is the National Health Program so assiduously championed by the employes of so many Federal bureaus.

* * *

ARTICLES ON INJECTION TREATMENT

During the life of John H. Patterson, former President of the National Cash Register Company, he constantly emphasized the fact that one picture is worth ten thousand words.

Dr. Russell A. Winters of Chicago certainly believes this in view of the new series of articles appearing in Clinical Medicine & Surgery (the first one is appearing October, 1939 followed by another one in the November issue, and we understand subsequent articles will appear in January, February and March issues).

This series of articles by Dr. Winters has very little type matter but has very explanatory illustrations and diagramatic references to the illustrated subject.

Particularly is this type of treatment valuable in "getting over" the technic used in injection treatments and in the manipulative methods preceding or following injections.

Any doctor interested in injection treatments for arthritis, rheumatism, brachial neuritis, subdeltoid bursitis, injured tendons, etc., particularly in relation to muscle congestion of the shoulder, hip, knee, leg, foot, or low back pain, etc., will do well to secure reprints of Dr. Winters' articles appearing in Clinical Medicine & Surgery.

These may be secured by addressing the Farnsworth Laboratories, 28 E. Jackson Boulevard, Chicago, Illinois, who are offering reprints to the medical profession without charge.

* * *

THE FIGHT ON CANCER

Tens of thousands of lives — formerly doomed — are now being saved from cancer, Clarence C. Little, Sc. D., Managing Director of the American Society for the Control of Cancer, declares in a thirty-two page pamphlet "The Fight On Cancer," published recently. This pamphlet is the 38th of a series issued by the Public Affairs Committee, an educational group which makes available in summary the results of research on economic and social problems.

"There is a rift in the black cloud of fear and ignorance which has long prevented frank discussion of cancer. Through this gap, knowledge gained by new types of research, improved treatment and organized education is pouring like powerful sunlight to bring vigorous activity and hope," Dr. Little says.

---

*Reprinted from The United States News, an independent weekly dealing with national affairs, published at Washington, D.C.

**Medical Director, Standard Life Insurance Co. of America, former President, Medical Society of Pennsylvania.

The pamphlet reviews the developments in the field of cancer control in recent years and presents the latest information on the statistical and medical aspects of the problem, progress in research, and an outline of the educational program through which the aid of the general public is being enlisted.

Dr. Little attacks quacks, including out-and-out crooks and those who honestly but mistakenly believe that they have a successful "cure".

He also emphasizes the importance of group treatment of cancer and the development of cancer clinics certified by the American College of Surgeons.

In his section on research, Dr. Little declares that the methods of study of the cause and nature of cancer have changed greatly in the last thirty years. Among the chief instances of progress in the field he notes:

> The development of techniques of increasing deliberately the supply of cancer by "the discovery that mouse cancer could be successfully transplanted into other mice — unless infection due to carelessness is introduced the life of cancer appears to be limitless."
>
> Experiments with chemicals, notably tar derivatives, which when applied repeatedly to tissues of rabbits or mice "result in the overgrowth of the affected area, frequently leading to cancer. The development of this line has been startling and extensive. Today, perhaps fifty substances, most of which can be made in the laboratory, can be used to cause cancer."
>
> The use of mice inbred for fifteen or twenty generations to produce experimental animals of "a very high degree of biological uniformity — in some of the strains continuous observation has been practiced for more than a hundred successive generations."
>
> The growing cultures of cancer cells outside the body, permitting observation and study under the microscope and recording of activity by motion pictures.
>
> The measuring and recording of the internal chemistry of the cancer cell, a field whose future development should be great.
>
> The discovering of the importance to cancer of glandular secretions. "These secretions have in them chemical substances called hormones. The importance of such hormones to the development and function of the body in general and of cancer in particular cannot be overestimated."

"We are impressed with the fact that more knowledge of the existing needs in cancer research is called for," Dr. Little says, "and it is hoped that this produces increased funds."

* *

At the Third International Neurological Congress held in Denmark during the summer of 1939, Doctor John F. Fulton of New Haven presented a paper on "Central Levels of Autonomic Function, with Particular Reference to the Cerebral Cortex and the Endocrine Organs."

* *

PRESENT NEEDS

Is it not obvious that what is most needed today in this enormously rich but very discontented country of ours is a clearer perspective on life as a whole? True, there are doubtless many things that need correction, in medicine and everywhere else. Manifestly, the millennium cannot be reached overnight. Perfection is not to be attained by legislative fiat. What is needed now, above all things, is unselfish, enlightened civic leadership. Here is where, I submit, our professional men — our doctors and our lawyers, our journalists and our teachers — have a duty to perform that they cannot delegate to anyone else. They, above all others, are equipped to see the necessities of our situation and to suggest appropriate remedies. And as we cast our eyes today toward Europe can there be any doubt that our greatest duty is the preservation of our ancient liberties?

"For what avail the plough or sail,
Or land or life, if freedom fail?"

You may ask what all this has to do with meeting subversive attacks on modern medicine. I give you my answer without hesitation. The physician, like the lawyer, must be a citizen first or he will eventually find that he is not a physician at all. If you doubt this, I ask you to look at the plight of professional men in the totalitarian states of Europe. Every physician when he takes the Hippocratic oath, every lawyer, when he signs the roll of his court on admission to the bar, should also be obliged to take an oath like that taken by the boys of Athena on admission to the army:

"We shall never bring disgrace to our city, by any act of cowardice, nor ever desert our suffering comrades in the ranks. We will fight for the ideals and sacred things of the city, both alone and with many. We will revere and obey the city's laws and do our best to incite a like respect and reverence of those above us who are prone to annul or to set them at naught. We will strive unceasingly to quicken the public's sense of civic duty. Thus, in all these ways, we will transmit this city not only not less, but greater, better, and more beautiful than it was transmitted to us."

Once the disinterestedness, the capacity for leadership, and the vision of our professional men have been accepted by their fellowmen, I have little concern as to the correct solution of purely professional problems. They will be solved the country over, as they are being solved today in your state and mine, by patiently seeking out what is needed in each community and then devising the best available ways and means of satisfying those needs, even though they may involve some departure from what has heretofore been done. Such methods cannot fail to carry their appeal to an intelligent public.

Wis. Med. Jour. Nov. 1939

—☆☆—

DR. JAMES G. CARR AWARDED 1939 MISSISSIPPI VALLEY MEDICAL SOCIETY'S DISTINGUISHED SERVICE AWARD

Dr. James Gray Carr, A.B., M.D., F.A.C.P., of Chicago, Secretary and Professor of Medicine, Northwestern University School of Medicine, was awarded the Mississippi Valley Medical Society's Distinguished Service Award for 1939 at the recent annual meeting of the Society held at Burlington, Iowa. Dr. Carr was presented with the gold medal award and a certificate by the President of the Society, Dr. M. Pinson Neal, Prof. of Pathology, University of Missouri School of Medicine, at the annual banquet on September 28. The award is given annually to an active member of the Society for "unusual and distinguished service to the medical profession."

CONSULT WI' A SIP!

One sip o' Johnnie Walker wi' soda will convince ye that all's well wi' this grand whisky. Aye, it will tell ye that there's no finer whisky than Scotch... and Johnnie Walker is Scotch at its smooth, mellow best!

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820...
still going strong

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importers*

SILVER PICRATE *Wyeth's*

has shown a

CONVINCING RECORD OF EFFECTIVENESS
***in* ACUTE ANTERIOR URETHRITIS**

due to Neisseria gonorrheae

The record is based on rigid clinical and laboratory signs before and after treatment.*

1. **Fresh smear**
2. **Fermentation of dextrose**
3. **Acid formation in maltose**
4. **Agglutination test**
5. **Alkali solubility test**

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in Anterior Urethritis: Wyeth's Silver Picrate Crystals used in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genito-urinary and gynecological practice will be mailed on request.

JOHN WYETH AND BROTHER, INC. • PHILADELPHIA, PA.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

Directory of Medical Specialists

The new Directory of Medical Specialists is the only official directory of the specialists, certified by the twelve special American Boards and the two affiliated Boards. It lists approximately 14,000 names and is entirely new, complete, and up to date. A separate section is devoted to each American Board, with both a geographic and a biographic listing of its Diplomates. In addition, there is a complete alphabetic list including all the 14,000 Diplomates. In this lists are addresses and indications of speciality certification, while in the geographic sections biographic information is given. The Directory provides full details of the organization and examination requirements of each of the existing American Boards. The book itself is a sturdy, handsome volume, with all data in large, legible type for quick reference use and for constant service. The page size is six inches by nine inches, and the book contains approximately 1,400 pages. In spite of the large size of the book and the care which has gone into its production, the list price is only $3.50. The Directing Editor is Paul Titus, M.D. and the Associate Editor, J. Stewart Rodman, M.D.

⁂

THE BLUE CROSS ABUSED

Apparently the privileges of the Associated Hospital Service Corporation of Massachusetts, known as the Blue Cross, have been abused by both doctors and patients. Patients have been sent. to hospitals by physicians under non-emergency conditions for diagnostic purposes or periodic health examinations, neither of which is included in the contract, and patients are remaining in hospitals extra days at the expense of the Blue Cross. Changes have now been made "to insure future stability and to protect the interests of all participants." X-ray and anesthesia benefits are eliminated; maternity benefits are limited to half the hospital bill; tonsil and adenoid operations are not included during the first year of membership. During two years of operation 225,000 subscribers were enrolled and total hospital bills amounting to $1,225,000 for 25,000 patients were paid. This sum represented about 85 per cent of the earned income for the period.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1939-1940) 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) 5

ORIGINAL PAPERS:

The Revised Nurse Practice Act — . . . Agnes K. Ohlson, R. N., Hartford, Conn. 63

Congenital Arteriovenous Fistulas with reports of two cases — Benedict B. Landry, M.D., Hartford, Conn. 64

Problems of Obstetric Practice in Rural Areas of the United States — Edwin F. Daily, M.D., Washington, D. C. 69

Therapeutic Aids in Otolaryngology . . Frederick N. Sperry, M.D., New Haven, Conn. 74

Crystalline Zinc Insulin with Protamine . . Barnett Greenhouse, M.D., New Haven, Conn. 78

Vitamin Deficiencies with Special Reference to Those Involving the Nervous System — Edwin F. Gildea, M. D., New Haven, Conn. 83

Controlled Physically Induced Fever, A Safe and Valuable Addition to Therapeutics — William Benham Snow, M. D., New York City 88

Industrial Medicine of Tomorrow . . Clifford Kuh, M. D., Dr. P. H., New Haven, Conn. 94

Occupational Dermatoses from the Viewpoint of the General Practitioner — John G. Downing, M. D., Boston, Mass. 96

EDITORIALS:

The Problem of Lung Abscess 101

Connecticut Clinical Congress 102

Economic and Social Aspects of Diabetes 103

Cause and Effect 104

Uncle Sam Counts Noses Again 106

FROM THE SECRETARY'S OFFICE 107

GENERAL PRACTITIONER'S FORUM 110

OUR NEIGHBORS 111

NEWS FROM COUNTY ASSOCIATIONS 112

SPECIAL NOTICES 115

OBITUARIES:

Henry Lawrence Swain, M. D. . . . . George Blumer, M.D. 61

Edward Augustus Stratton, M.D. 116

Alfred Frank Hewitt, M.D. . . . . Robert M. Carpenter, M.D. 116

QUARTO NOTES (Book Reviews) 118

MISCELLANEOUS:

Report on Tuberculin Tests in Middletown — M. L. Palmieri, M.D., M.P.H., Middletown, Conn. 87

New Provisions of Federal Old Age and Survivors Insurance Effective January 1, 1940 . . 93

New Health Insurance Bill — Redrafted by American Association for Social Security . . 108

THERAPEUTIC DISCOVERIES

attain full significance only when their wide clinical application is realized. The problems of large-scale production and distribution fall to the pharmaceutical manufacturer, and prompt solution depends upon adept research, experience in manufacturing, and facilities for placing the new drug at the disposal of every physician.

Orally Administered Bismuth in the Treatment of Syphilis

PULVULES SOBISMINOL MASS, LILLY, in a dose of two or three pulvules three times daily, rapidly produce a high urinary bismuth excretion and exert a powerful antisyphilitic effect. To guard against inadequate treatment through irregularity of administration, Sobisminol Mass may best be regarded as an adjunct to parenteral therapy.

AMPOULES SOBISMINOL SOLUTION, LILLY, in doses of 1 or 2 cc. injected intramuscularly twice weekly, are equally effective and may be used alone or in conjunction with Sobisminol Mass. Sobisminol preparations contain a complex organic bismuth compound resulting from interaction of sodium bismuthate, triisopropanolamine, and propylene glycol.

A convenient test kit
for determination of urinary
excretion of bismuth is available.

ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA, U. S. A.

HENRY LAWRENCE SWAIN

HENRY LAWRENCE SWAIN

1864-1940

About 1659 some nine or ten families migrated from the American mainland to the Island of Nantucket. Among these was Richard Swain, and Henry Swain was a direct descendent of his. Inasmuch as intermarriage took place between these different families, — the Starbucks, the Coffins, etc., — Henry also descended from some of these, notably Tristram Coffin. It is of course well known that as the population of Nantucket grew there was a period when it was one of the chief whaling centers of the world. The island produced many able-bodied seamen, and Henry Swain's father, George Hussey Swain, was a master mariner, the captain of a clipper ship, who twice rounded the Horn and who went on voyages which lasted for three and four years and extended to the Pacific Islands and to China. Captain Swain no doubt regaled Henry in his youth with the stories of these excursions. Indeed, he actually wrote an account of his experiences but this was unfortunately lost by the family and was never published. Henry never lost his interest in the Pacific, and the story of the "Mutiny on the Bounty" particularly intrigued him as his father had actually visited Pitcairn Island. Of Henry's mother, Henrietta Weeks, but little appears to be known.

The first nine years of Henry's life were spent on the Island of Nantucket, and his early education was received at the famous "Cent School," which was supported by each pupil bringing a cent in his dinner pail every day. It is a tradition in the Swain family that even as a small child Henry had leanings towards the healing art and that he made up sugar water and bread pills and went around dosing his family and friends. When he was nine years of age his father moved to New Haven and Henry's education was continued in the public schools of that city. Oliver T. Osborne, who was a classmate of his in his high school days, records that Henry was an excellent student and that at the time of his graduation the valedictory remarks, which were made by the students of the highest rank, were delivered by Swain, Osborne, and a student called Linsley, who later became a well known Episcopalian clergyman.

At the time Henry Swain entered the Yale Medical School admission was based on a certificate of graduation from a high school, and this accounts for the fact that when he graduated in 1884 he was only twenty years of age and could not therefore legally practice medicine. The old record books which contain his marks are still preserved and show that he was an excellent student. On graduation he decided to go abroad and he went in company with his friend and classmate, Oliver T. Osborne, to Leipzig. Here Henry Swain spent two profitable years, the major part of his work being done under Professor Hagen, who was Professor of Laryngology and well-known authority on the subject. Dr. Osborne states that in addition to his work in laryngology Swain also took courses on diseases of the eye, ear and nose. Henry Swain was a good linguist and during his first summer holiday in Germany he went into the Hartz Mountains and lived in a German family so that he could acquire the language more competently. Professor Hagen made him his assistant, both in his clinic and in his office, and during Swain's second year the Professor was sick and it fell upon Swain to carry on a good deal of his work, good evidence of his linguistic ability. Swain's Arbeit under Hagen had to do with the so-called lingual tonsil, and it is stated that Henry Swain was probably the first to adequately describe this structure. I have been unable to find a definite reference to the publication of this article in the Index Catalogue of the Surgeon General's Library, although there is little doubt that it was actually published.

On his return from Germany in 1886, Swain opened an office on York Street and here he remained for many years, in fact until he moved his offices into the Colonial Building on the corner of Church and Elm Streets, where he spent the remainder of his professional career.

When Dr. Swain returned to New Haven in 1886, he was appointed Lecturer on Diseases of the Throat and Ear in the Yale Medical School and this position he held until 1895. During 1888 and 1889 he also acted as Demonstrator of Anatomy. In 1895 he was appointed Clinical Professor of Diseases of the Throat and Ear, and this title in 1902 was changed to Clinical Professor of Laryngology and Otology. In 1915 his title was changed to Clinical Professor of Otology, and in 1935 Dr. Swain became Emeritus Professor of Otology. He was the Consulting Laryngologist to the New Haven Dispensary from 1887 to 1940 and Consulting Laryngologist to the New Haven Hospital from 1893 to 1940. Dr. Swain applied himself conscientiously to the work involved in connection with these different positions and gained the complete confidence of his colleagues as a teacher and a physician.

Dr. Swain was interested not only in his hospital and dispensary work and in his teaching but also in the work of both local and national medical societies. He was a member of the New Haven Medical Society from 1887 to 1940 and was its President quite early in his career. He took an active part in the affairs of the County Society. He represented the County Society as Councilor to the State Society for several years. He was prominent in the affairs of the American Laryngological Association, of which he was President in 1901. On May 24, 1939, Dr. Swain was given honorary membership in the American Laryngological Association, being at that time one of four men in the United States on whom this honor had been conferred. He was a charter member of the New York Laryngological Society. Dr. Swain was not only interested in the work of the various societies with which he was associated but always took an active part in the discussions when subjects in which he was especially interested came up in meetings. Dr. Swain was also interested in tuberculosis, and his name appears among the original incorporators of the Gaylord Farm Sanatorium. He was a Mason for fifty years and was also a member of the New Haven Historical Society and the Connecticut Academy of Arts and Sciences.

Dr. Swain contributed to medical literature from time to time. There were certain subjects in which he was particularly interested, notably bronchial asthma and diseases of the adenoid tissue in the nasopharynx and pharynx. He was probably the first to use suprarenal extract in nose and throat work and his paper on "The Local Use of the Aqueous Extract of the Suprarenal Glands of the Sheep in the Nose and Throat" appeared in the New York Medical Journal for 1898. Most of his papers on asthma, which covered both its relation to nasal disease, its origin, and particularly its surgical treatment, appeared between 1892 and 1900. Dr. Swain was the first man, in all probability, who removed adenoids and tonsils in Connecticut and certainly one of the very first to do this operation in New England. In his later life he became very conservative with regard to tonsil operations and frequently preferred their gradual removal by coagulation or cautery to the radical operation.

It is of course difficult to appraise at such close range the achievements of any man. There can be no doubt, however, that Dr. Swain was one of the outstanding American laryngologists of his time. He had excellent training, he was a student, he had good judgment, and his contributions to the subject showed evidence of an alert and active mind constantly on the lookout for new developments. His personality was a distinguished and a pleasing one. Many of his patients became sincerely attached to him, his students admired him, and his death is a loss both to his patients and to his confreres.

George Blumer, M. D.

The Connecticut State Medical Journal

VOL. IV. FEBRUARY, 1940 No. 2

The Revised Nurse Practice Act*

AGNES K. OHLSON, R.N.,†
Hartford, Conn.

Before discussing the revised Nurse Act, I will summarize a few of the items of interest with reference to the schools of nursing. The annual reports show that the number of students in Connecticut schools of nursing on July 1 was 1445, as compared with 1414 in July 1938. These same reports showed an increased number of organizations planning a more nominal number of hours per week for students and graduates. In fact, eight of the organizations reporting have a 48-hour week or less for their nurses. The sooner organizations employing nurses can arrange for hours consistent with the hours for other groups of similar age and preparation, the less anxious labor organizations will be to control nursing hours through legislation. Practically all of the students now admitted to schools of nursing take a classification test. The results are proving of value in the selection of students, as well as a means of guidance for the students admitted. From the standpoint of State Board examinations, even though the examinations are perceptibly harder, we have fewer failures, which indicates a better selection of students and better teaching. The Advisory Committee and the members of the State Board of Examiners for Nursing have discussed the matter of changes in subjects for examination, and definite action will be taken regarding this at the next meeting. Because of the inconsistency of various states in regard to examinations, a group has for some time been working on the formulation of comprehensive examinations which will be a valid test of the individual's ability to care for the sick. Such a method of testing on a national basis will be of value to the applicants and to the individual schools. We are glad to say that Connecticut graduates were the first group to participate in this project, which is still in the experimental stage, and our group is thus helping to establish the validity of the tests now formulated.

The Advisory Committee to our Board, to which your organization has appointed two members, has met twice. The meetings have been lengthy and the discussion thought-provoking. We anticipate much help from this Committee in the discussion of necessary changes of policy and in dealing with matters of interest to hospital, medical, and nursing groups.

The revised Nurse Practice Act which became effective in July 1939, requires licensing for those who care for the sick for hire. The only essential exceptions to this law are the individuals employed in State Hospitals or State Sanatoria and the individual caring for a patient in the patient's own home. At first, this does not appear essentially different from our earlier law. However, closer analysis has shown that it requires licensing of personnel in the large number of private hospitals and convalescent homes throughout the state. We now have some 200 such hospitals and homes in this state, caring for approximately 2000 patients. It is estimated

(*Continued on Page 109*)

---

*Presented at the Annual Meeting, Connecticut State Hospital Association, November 17, 1939.
†Secretary, Board of Examiners for Nursing.

Congenital Arteriovenous Fistulas

With Reports Of Two Cases

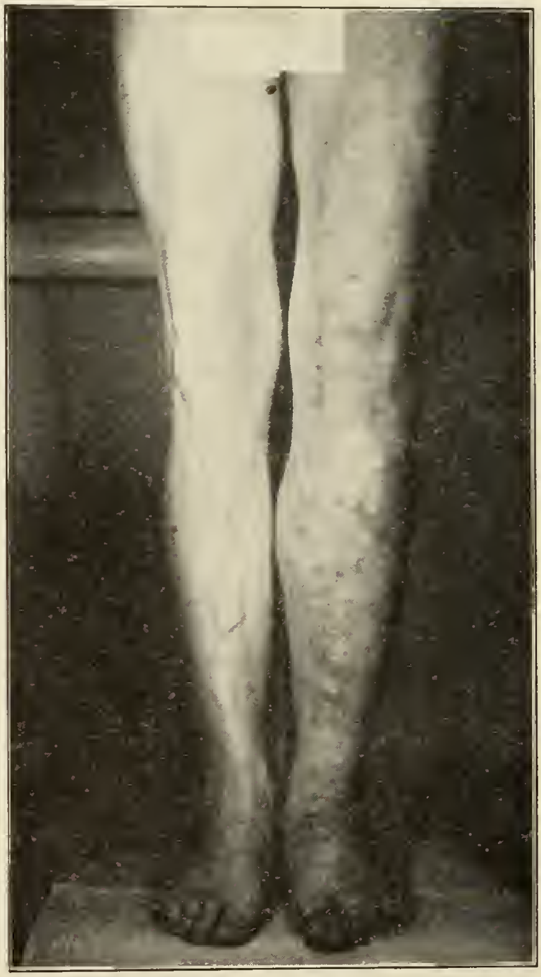
BENEDICT B. LANDRY, M.D.,*
Hartford, Conn.

Reports in the literature concerning the condition of congenital arteriovenous fistula are slowly being added to although the total number to date is probably under 100. O'Neil in recently reporting 13 cases of his own, one of which was helped by multiple fistula ligation along with injection treatments, commented that "such fistulas are still sufficiently rare to warrant reporting all cases." Horton of the Mayo Clinic reported 38 cases in 1934, and Lewis, 30 cases in 1930.

We desire to augment the list by 2 cases, one a male in whom one of the lower extremities, the left gluteal region and the lower back were involved and the other a girl in whom the right lower arm and hand were affected. Considering the rarity of the condition, it is noteworthy that both of these patients were seen for the first time within a month of each other, one being a private patient and the other, the male, being referred to the surgical service for treatment of varicose veins.

Definition

By congenital arteriovenous fistulas are meant certain anatomic anomalies of the vascular system present, of course, from but not necessarily noted at birth, the abnormalities consisting of communications between arteries and veins without the arterial blood passing through the capillary bed. While perhaps a single communication between a small artery and small vein may be more frequent than is generally supposed and because of the small size lacking in symptoms and signs, the connections are apt to be quite multiple, occurring most often in the extremities. Because of involvement of these regions, and because such abnormal communications give rise to changes like to those found in association with varicose veins, such fistulas are apt to be confused with varicose veins. A large fistula between an artery and vein or multiple fistulas between large arteries and veins are almost always acquired, for example, from stab or gunshot wounds, but whether congenital or acquired, these large ones sooner or later give rise to signs and symptoms such as hypertrophy of the heart, dyspnoea, bradycardia, etc.



Showing greater distribution of varicosities along outer aspect of leg and thigh. Internal Saphenous System not involved to any great extent.

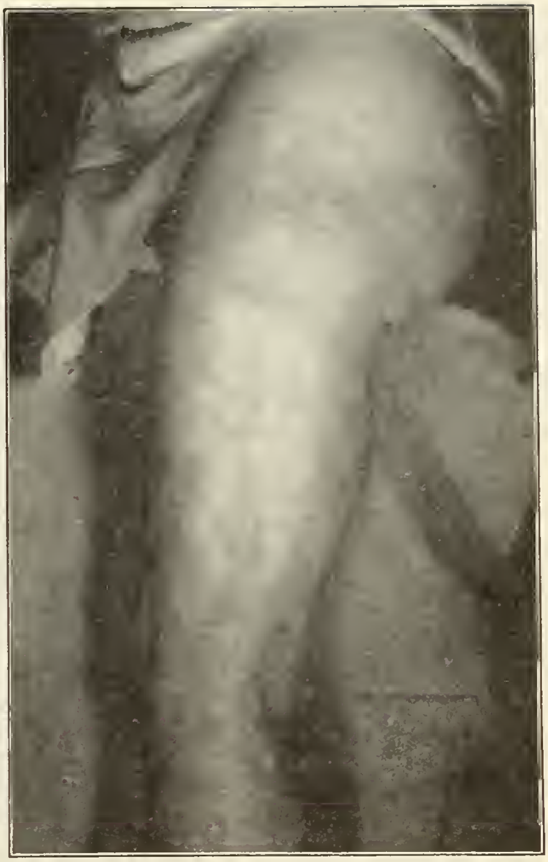
---

*Attending Surgeon, St. Francis Hospital, Hartford, Conn.

Diagnosis

This discussion in the main concerns the extremities. Cases diagnosed as varicose veins which prove refractive to usual treatment or in which the distribution of the varicosities is more on the outer aspect of the legs and thighs or even the buttock, that is, not involving the internal saphenous system, should bring forth the suggestion that the condition of arteriovenous fistula is present. The diagnosis can usually and readily be made by comparing blood withdrawn from a vein of the affected extremity with that taken from the median basilic vein of the normal arm of the patient. While it is better to withdraw such specimens of blood simultaneously, one individual taking it from one vein and another from an affected extremity, the variation of the oxygen of the bloods is so marked as a rule that time is sometimes allowed for one operator, with all facilities immediately available, to withdraw and compare the two specimens of blood by himself. Viewed scientifically, in any case, actual determination of the oxygen saturation of the blood would be better and in some cases, perhaps the minority, it is essential as a differential procedure. The blood taken from the varicose vein or vein in communication with an artery by way of a fistula, will of course, be redder than the blood from a normal vein. Comparison of specimens in ordinary test tubes by daylight is sufficient.

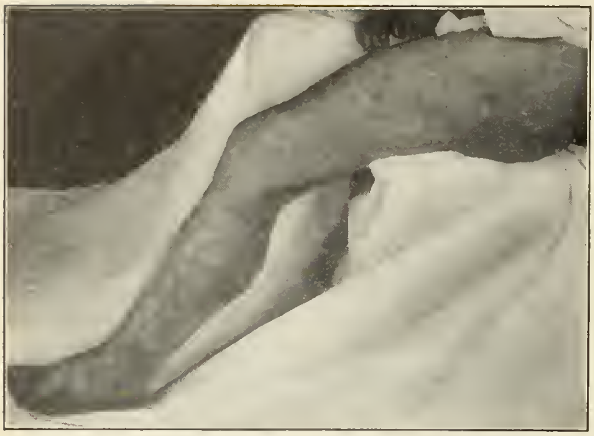
Many cases, particularly the early ones, are diagnosed as varicose veins and in many patients local attempts at cure have been made as evidenced by one or more incisions in the region of venous tufts, sacculations or swelling. All gradation of complaints and signs such as one might expect from the disturbed vascular system of a part are found, varying from only an easy fatigue of the extremity, a feeling of heaviness or a burning sensation, such as were noted in the female patient, up to the marked trophic changes, swelling, edema, ulceration, discoloration, eczema and even the marked disability which the male patient suffered.



Infra-red Photograph

Too much stress should not be placed upon the finding of a bruit or thrill. Horton has pointed out that such are found in only 25% of the cases. The same might be said for increase in the length of the limb, although no exact figures are available concerning the frequency in the findings of variation of the size of corresponding extremities. O'Neil has stated that "lengthening in the bones usually occurs provided that the fistulas are present before the epiphyses fuse to the shaft." Since by their very nature and designation, these fistulas are congenital, they must be present before epiphesial fusion is anywhere near complete. Significant is the fact that in the older patient, age 59, with multiple fistulas, there was no difference in the length of the femurs. We believe the difference in size when it occurs to take place mainly because of increase in blood supply in cases extensive from the beginning in which communication between arteries and veins are in the bones themselves. Hypertrophy of the heart is uncommon in the congenital type while the reverse is true in the acquired, so much so that physicians are consulted because of the marked dyspnoea rather than for the fistulous condition.

Blood changes consisting of a rise in systolic pressure and a lowering in diastolic pressure have



Lateral view showing involvement of gluteal region.

been reported as well as an increase in the total volume of blood as one might expect. The difference in blood pressure in extremities is perhaps more generally found in those cases which are large enough to give a bruit. Even pulsation of veins has been reported. The temperature of the affected extremity is apt to be higher than the normal.

Undoubtedly the two most valuable diagnostic procedures in the congenital type of arteriovenous fistula are: 1. The determination of the oxygen content of the blood in the affected extremities or part and its comparison with the oxygen content of a vein of a normal extremity or part; 2. The arteriogram and infra-red photographic methods of visualization. The latter is quite satisfactory and of course, does not entail the risk of injecting thorotrast into the artery.

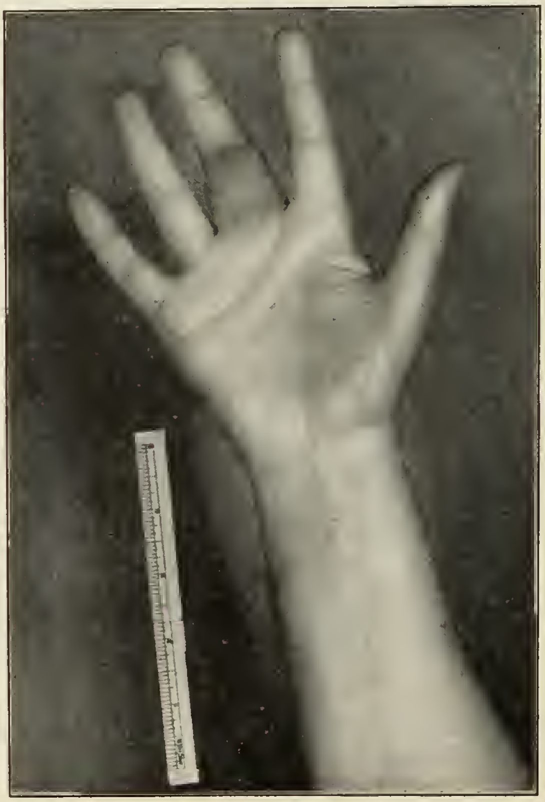
Treatment

As one might expect because of the frequent multiplicity of fistulous communication, operative treatment is quite unsatisfactory. Occasionally, as in one of O'Neil's cases, operation leads to marked benefit. He ligated eight separate fistulas between the femoral artery and vein over a length of vein extending from the saphenous opening to the junction of the lower and middle thirds of the thigh. Where the condition progresses to the condition of marked ulceration as in the patients of Gilmore and Bolam, amputation has to be considered and is at times necessary.

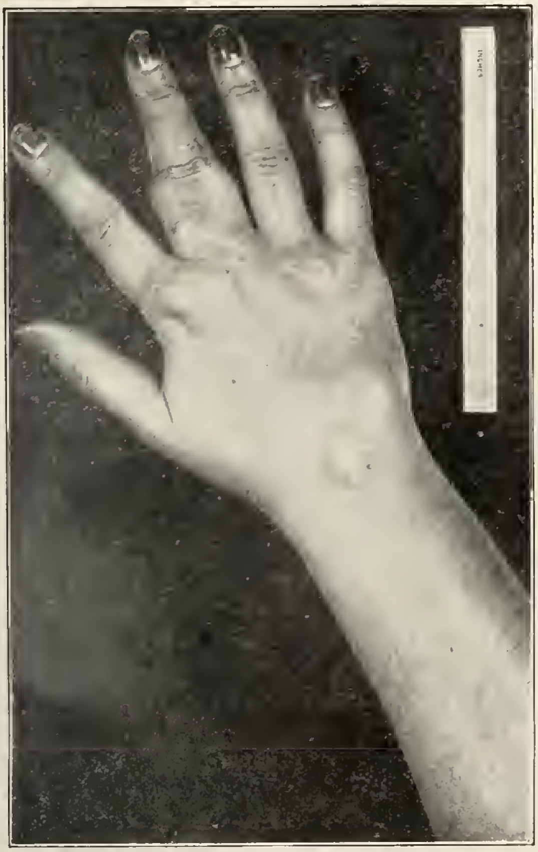
Despite the fact that we cannot with certainty occlude every fistulous communication by injection treatment and in spite of the undoubted necessity of repeating injections in these cases, this form of treatment has given a great deal of benefit in many cases as it did in ours. In one of our cases, the male, who at times had to creep about because of the pain, there was a change from an individual unable to work to one who carried on laboriously. In the female patient, besides the cosmetic improvement, the right hand and forearm were stronger.

The rationale of the treatment is simple. In the vein injected, a venitis is set up, organization takes place and the entrance of arterial blood to the varicose is blocked. Perhaps there is much less chance of recanilization than in the ordinary varicose vein since one might look for some continuation of the intima of the artery to further aid in the blocking of the fistula.

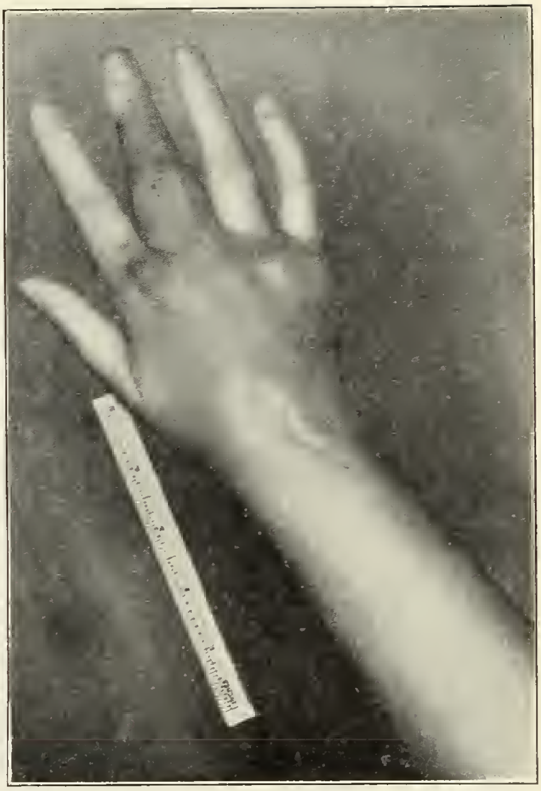
No set rule for frequency or amounts of injected material can be laid down. Arbitrary amounts varying from 0.2 cc. up to 5 cc. depending on the size of the varices may be used at fairly frequent intervals. Persistence and patience are necessary until all visual or palpable enlargements of the veins have been subjected to successful injections.



Showing bulbous enlargement of middle finger.



Some idea of other areas than middle finger. Scars of previous attempts at cure seen over wrist joint.



Infra-red Photograph

Case History: C. B., Male, Age 59. Admitted 1-13-39 with a chief complaint of "swollen leg." He stated that the left leg had been more or less troublesome since youth and had been discolored and larger than the right leg since birth. About one year ago he started to experience pain in the left hip region which interfered with sleep and locomotion. At times he could little more than crawl about. He had been told on several occasions that he had varicose veins and he was referred from another hospital to us for treatment for that condition.

Phys. Exam. — Other than left leg and left gluteal region — Negative.

Lab. Data — Kahn and Hinton Test — Negative. HBG., 77%. RBC, 4,300,000. WBC, 8,100. Differential, Normal. Urine, Normal. X-rays showed both femurs to be about equal in size. The arteries, however, showed considerable atherosis.

Description: The left extremity was considerably swollen and discolored. It was reddish and had a blotchy appearance, the blotches being a port-wine color. This redness extended from the dorsum of the left foot up the lateral and posterial aspects of the leg as far as the gluteal region and lower back of the left side. Interspersed throughout the discolored areas are dilated veins and venules. The dilation of the veins is variable, the larger varicosities being present on the lateral aspect of the extremity. The medial aspect of the leg had no varices. The right leg was normal.

The Trendelenberg Test was normal as was the Perthes Test. The Dorsalis Pedis artery pulsation could be felt easily on either foot.

On January 19, about 3cc. of blood from the right median basilic vein and from a large dilated vein over the left buttock were withdrawn simultaneously and compared. There was a difference in color between the specimens which was immediately obvious to the physician, nun and nurses present. This gross test proved the test to be congenital arteriovenous fistula, most likely with multiple fistulas.

The next day injections with sodium morrhuate were started and repeated every two days in amounts varying from 0.2 cc. up to 5 cc., depending on the size of the varices. After one week there was no further pain in the extremity and after about three and one-half weeks most of the dilated veins had been injected. There was much less swelling of the leg.

The patient was discharged on Feburary 25 and was last seen on August 10, 1939, when he stated that he felt very well and was working daily.

Case History: Miss E. V., Age 30. First seen on December 1, 1938, when she came in complaining of indigestion. During the physical examination the condition described below was noted. Following diagnostic measures in relation to the indigestion and improvement of this

(Continued on Page 68)

THE OFFICE NURSE

Under Chapter 355, "An Act Concerning the Practice of Nursing" passed by the 1939 Connecticut General Assembly, no individual may care for or treat any person under the direction of a physician unless properly certified as a Trained Attendant. This requirement applies to the "office nurse" who is not a Registered Nurse licensed in Connecticut. Attention of our readers was called to this new law in the January issue of the Journal and to the fact that certification may be effected by means of a waiver if attended to before July 1, 1940, when the waiver expires. Such attendants in the employ of physicians must be properly licensed or they will be subject to a fine of not more than $100.

We quote from the Nursing Practice Act —

Section 5. *Certification as a Trained Attendant.* Any person twenty-one years of age or over of good moral character, who is a citizen of the United States or has legally declared his or her intention of becoming one and who holds a certificate from an institution approved by said board, which gives a course of not less than twelve months' instruction in the care of the sick as prescribed by said board, or its equivalent as determined by said board, shall be eligible for examination for certification as a trained attendant upon payment of a fee of five dollars. Such examination shall include such subjects as the board shall determine. If such applicant shall pass such examination to the satisfaction of said board, said board shall issue to such applicant a certificate as trained attendant which shall constitute a license to practice as a trained attendant in this State.

Section 6. *Reciprocity for Trained Attendants.* Any person certified as a trained attendant, or as a person entitled to perform similar services under a different designation, in another state whose requirements for certification in such capacity are equivalent to those of this State, upon furnishing satisfactory proof to said board that he or she is a citizen of the United States or has legally declared his or her intention of becoming one, at the discretion of said board, may be eligible for certification in this state and entitled to a certificate without examination upon payment of a fee of five dollars.

Section 7. *Who May Use The Title "Trained Attendant".* A person who has received such a certificate shall be styled and known as a "Trained Attendant" and no other person shall assume such title or use the abbreviation "T.A." or any other words, letters or figures which indicate that the person using the same is a trained attendant.

Section 8. *Waiver For Those Wishing To Secure A "Trained Attendant" Certificate.* Said board shall issue a certificate as a trained attendant, provided application shall be made before July 1, 1940, to any person who shall submit satisfactory evidence that he or she is at least twenty-one years of age, is of good moral character, is a citizen of the United States or has legally declared his or her intention of becoming one, has been a resident of the state of Connecticut for three years prior to July 1, 1939, has had three or more years of experience in the care of the sick for renumeration prior to July 1, 1939, and whose application for a certificate as a trained attendant is indorsed by two physicians licensed in Connecticut who have personal knowledge of the applicant's qualifications and by two persons by whom he or she has been employed.

☆☆

CONGENITAL ARTERIOVENOUS FISTULAS

(*Continued from Page 67*)

condition, the fistulas of the right hand and forearm were injected with sodium morrhuate.

Description: The proximal one-half of the right middle finger was greatly dilated and bluish in color. This bulbous enlargement extended all around this part of the finger, being soft to palpation. On the dorsum of the hand there were other bluish, dilated veins. Blood was taken from one of the dilated areas and then blood was withdrawn from the median basilic vein of the right arm and the contrast even though the bloods were not withdrawn simultaneously, was very definite and even obvious to the mother of the patient. Injections were started, using small amounts, that is, from 0.2 cc. up to 0.5 cc. two or three times weekly. Unfortunately, a severe respiratory infection has caused an interruption of the treatment but improvement was satisfactory enough so that the patient desires to carry the treatment to completion at a later date.

BIBLIOGRAPHY

1. O'Neil, E. E., N. E. Jour. Med., Vol. 221, 4:133-136, July 1939.
2. Lewis, D. Lancet, 2:621-680, 1930.
3. Horton, B. T., Med. Clin. - No. Amer., 15:227-232, 1931. Horton, B. T., Proceedings of Staff, Mayo Clinic, 9:460-463, (Aug. 1) 1934.
4. Gilmour, J. Bolam, M. Brit. Jour. Surgery, Vol. 25, 337-343, Oct, 1937.
5. Reid, Mont R., Johnson, McGuire. Annals Surgery, Vol. 108, 643-693, 1938.
6. Wise, Walter, Lisansky, E. T., Annals Surgery, Vol. 108, 701-704, 1938.

☆☆

THE EPHRAIM McDOWELL-JANE TODD CRAWFORD MEMORIAL HOME

The Kentucky Medical Journal issued a supplement to its November issue containing details of the dedicatory services of the McDowell-Crawford Memorial Home held at Danville on May 20, 1939. The supplement contains many interesting cuts, including one of The First Ovariotomy. Among the list of donors to the Home appear the names of four Connecticut physicians.

Problems of Obstetric Practice in Rural Areas of the United States*

EDWIN F. DAILY, M.D.,
Washington, D.C.†

Mortality reports for Connecticut for the past few years indicate that I should be coming here for advice from the obstetricians who can boast of the lowest maternal death rate in the United States. When Connecticut reported a maternal death rate of 25 for 1937 the vital statisticians in the United States Bureau of the Census rechecked every death certificate from the State, but no error was found and the rate remained the lowest ever recorded in the United States.

The problems of obstetric practice which have apparently been more nearly solved in this State than in the rest of the country are considerably different in various parts of the United States. Comparing problems of medical practice between States reminds me that as I studied and observed methods of maternal care in a few European countries last year I was continually impressed by the great differences between our huge country and their small countries. In the past there has been a tendency to compare medical problems in the United States with those of European nations. It cannot be done. More appropriate would be a comparison between one of their countries and one of our States. The geographic, racial, and economic problems affecting medical practice in Connecticut are far different from those of the congested population of New York City, the Negroes of Mississippi, the dry farmers of the Dakotas, or the migratory families in California.

There are more than 2 million live births in the United States each year (about one every 14 seconds). In addition there are approximately 75,000 stillbirths and an undetermined number of abortions.

Who delivers the mothers of these babies? Approximately 250,000 have no medical attention at the time of delivery. (In 713 of the 3,072 counties in the United States one-fourth or more of all women delivered do not have a physician). It is estimated that 250,000 are delivered by students, interns, and residents, and that approximately 200,000 are delivered by physicians trained as obstetricians. However, 85 per cent of the specialists in obstetrics practice in cities of more than 100,000 population; less than 1 per cent practice in rural areas (communities of less than 10,000 population). This leaves about 1,500,000 women, or two-thirds of the total, who are delivered by general practitioners. If only half of the 140,000 practicing physicians in the United States included obstetrics in their practice they would each deliver 20 patients a year, but *more* than half of the physicians do include obstetrics in their practice, so the average is less than 20 deliveries per year.

Where are these women delivered? More than half of all live births in the United States occur in the rural areas and 84 per cent of these births are at home. In 864 of the 3,072 counties in the United States there are no women delivered in hospitals, yet there are almost 200,000 live births reported in these same counties each year. The increased risk of mortality resulting from lack of hospital facilities within a county was shown by a report from New York State this year. The infant mortality rate, when the family lived in the same town as the hospital was less than one-half the rate when the family lived outside of the town. Another important economic fact should be kept constantly before us as we consider these problems, namely, the very uneven distribution of financial resources in the various States and consequent uneven distribution of facilities for care. It is a fact that one-fourth of all live births occur in 11 States that have 43 per cent of the national income and yet another fourth occur in 11 other

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

†Children's Bureau, Department of Labor.

States that have only 10 per cent of the national income. You can readily imagine the difference of the economic problems involved in obstetric practice in these two groups of States.

The attendants at birth and the place of birth have been mentioned. What is known concerning the quality of care rendered? Studies of maternal care and maternal mortality have been made by physicians in all parts of the country. These studies have shown that on the average more than 50 per cent of the mothers who died received *no* prenatal care (from 20 per cent in Philadelphia to 80 per cent in South Carolina). All of the many studies made by physicians on the preventability of maternal deaths have concluded that at least 50 per cent of the deaths were preventable. What are some of the factors affecting the quality of care rendered the rural patient (leaving out of consideration at this time the midwife situation)? We know that 84 per cent of the million live births in rural areas occur at home, more than three-fourths attended by physicians and one-fourth without any physician in attendance. The average physician going into general practice delivered less than 10 patients while in medical school and about the same number during his internship. Some medical students and some interns deliver no patients. Several medical schools and many internships are unable to provide home-delivery service. Few general practitioners have had sufficient opportunity to learn the best way to treat even the more common complications of pregnancy and labor. After beginning private practice the limited number of obstetric cases he has each year gives him little opportunity to improve his techniques. Rarely is there an experienced obstetrician in his own community on whom he can call for advice and consultation.

The large majority of his patients must be delivered in their own homes. Only those of you who have observed these homes in the rural areas of the Middlewest, the South, and the Southwest can appreciate the difficulties which are only too frequently encountered. The distance from the physician's office to the home of the patient in labor and the burdens of a general practice make it difficult for the physician to remain with one patient for many hours. This probably explains the widespread use of pituitrin, not to induce but to hasten the termination of labor. The report of the Michigan Medical Society of a study of 10,000 births in that State concluded that among the most striking defects of obstetric practice were the injudicious use of pituitrin, manual dilatation of the cervix, and manual removal of the placenta. Doctor Whitacre, now professor of obstetrics in Peking, China, spent 2 years in full-time educational work with the physicians of Tennessee. He told me of the frequent complaints from the local physicians about the bad pituitrin they purchased every now and then. "We give the patients the regular dose of one cc to hurry things up and sometimes the patient just up and dies; must be the bad pituitrin."

Although syphilis is still an important cause of stillbirths and infant deaths, blood tests on pregnant women are not routinely made by many physicians. Lapham found that in 1931-33 less than half of the patients receiving prenatal and medical care in Pike County, Miss., had a blood test for syphilis. A Michigan study of 10,000 consecutive births revealed that only one-third of the mothers were tested for syphilis. A similar lack of attention to this procedure has been reported from all parts of the country. Free laboratory service and free drugs for the treatment of syphilis are made available by practically every State health department. What possible excuse can be given for the failure to test for syphilis every maternity patient seeking prenatal care and to treat the infected patient?

Toxemia of pregnancy is still the leading cause of maternal mortality in many States, yet in your private practice and in the large maternity hospitals eclampsia has become relatively rare. There are indications that in certain areas, in addition to lack of prenatal care, nutritional deficiencies and possibly even climate may explain the high incidence of toxemias of pregnancy but early detection and competent medical care would prevent most of them from becoming serious. The high mortality from this condition often is the result of the difficulties of the attending physicians in providing continuous care to a patient living 10, 20, or 30 miles out in the country, his inability to hospitalize many of the serious cases, and a general lack of understanding of the advantages of conservative treatment. Even when hospitalization can be arranged, accouchement force and cesarean section are still the accepted treatment for eclampsia by many physicians.

Serious hemorrhage is one of the most feared complications facing the physician in rural areas. The refined techniques for treating placenta previa, premature separation of the placenta, and postpartum hemorrhage in well-equipped modern hospitals are difficult or impossible to apply in the home or even the smaller hospitals. Facilities for blood transfusion are rarely available. Surgery under such conditions, even when otherwise indicated, is likely to be more hazardous to the patients than conservative measures within the ability of the average physician. Almost a uniform finding of all mortality studies has been the large percentage of patients with placenta previa or premature separation of the placenta treated by version and immediate extraction with resulting trauma and fatal hemorrhage. The methods of controlling hemorrhages and the value of blood transfusion are not fully appreciated by all physicians practicing obstetrics. Complete, simple, and inexpensive equipment for blood transfusion can be made available in any hospital, no matter how small, provided there is a laboratory and, more important still, a physician or technician who knows how to type and match bloods. Lists of blood donors are often easier to obtain in small communities than in cities. Sterile intravenous fluids for use in the home are easily available to physicians today. Perhaps oxalic acid will prove to be as efficacious in preventing hemorrhage as it is reported to be in controlling hemorrhage. Then at least our worries about postpartum hemorrhage would be lessened.

Sepsis, the leading cause of maternal mortality, at last seems to be decreasing. The sepsis rate was 21 per cent lower in 1937 than in 1936. No, this was not due to sulfanilamide, for although this drug may prove to be of great value in the treatment, and we hope the prevention of puerperal sepsis, its use in the United States in 1937 was very limited and not widespread for the treatment of puerperal sepsis even in 1938.

The physician delivering patients in their homes in rural areas is often handicapped by the lack of any trained assistant. Working alone under such unfavorable conditions, many physicians soon follow the course of least resistance. Masks are the exception rather than the rule in spite of numerous reports in recent years of the frequency of infection transmitted from the nose and throat of attendants. The use of sterile gloves, although increasing, is far from the uniform procedure. Sterile preparation and drapes are rarely used by the physician working alone and the necessary equipment and assistance to suture lacerations properly or to control hemorrhage are not always at hand.

One other important factor should be mentioned: the facilities in smaller hospitals for the care of maternity patients. Most of us will agree that there should be at least a delivery room where only noninfected patients are delivered and that there should be facilities for the isolation of infected puerperal patients and newborn infants. I believe we could also agree that where consultation is available it should be obtained by less experienced physicians before they undertake major operative procedures. There are also certain minimum standards of nursing techniques for the care of maternity patients and infants that might well be adhered to. With the ever-increasing rate of hospitalization of maternity patients these problems deserve the most careful consideration. Unfortunately, they are not confined to small hospitals or rural areas. I know personally of one of our larger cities where even a year ago there was no facilities for immediate transfusion in any hospital and I learned of the many unnecessary deaths from hemorrhage which resulted. Among these same hospitals there was not one where cesarean sections were not performed in the same room where general surgical procedures were carried out, often upon infected patients. My assistant visited a small western hospital where in one ward three puerperal patients were being cared for alongside of patients with erysipelas, poliomyelitis, and infected wounds. Women delivered in such institutions would be far better off in their own homes. Only the concerted efforts of obstetricians and other physicians to improve such hospital conditions will prevent the strict and perhaps unwelcome regulations of hospitals which now exist in Chicago and New York City.

A few of the problems confronting physicians practicing obstetrics in rural areas have been mentioned. I believe you will be interested in a brief account of what State and local health departments are doing to improve the quality of maternity care.

Postgraduate Medical Education

Postgraduate medical education for practicing physicians, financed from maternal and child-health funds, is gradually being placed on a new basis. Where these courses in the past were chiefly sporadic refresher courses, the tendency now is to develop them as a permanent educational facility within the State. The refresher courses made it evident that the greatest need was for opportunities for the physicians practicing in small communities or rural areas to receive from time to time short clinical courses given in conjunction with medical schools and larger teaching centers. Public responsibility for undergraduate medical education has long been accepted in the United States, but only in recent years have educators realized the necessity of continued education to keep the practicing physician abreast of the ever-increasing developments of medical science. State health agencies realizing their joint responsibility with other State agencies and organizations are making a valuable contribution in this field. More than 10,000 physicians attended the post-graduate courses in obstetrics financed from maternal and child-health funds last year.

The State health departments in Pennsylvania, Illinois, Michigan, and Indiana, in cooperation with the State university medical schools, are now providing short courses in conjunction with the larger teaching centers where local physicians can observe and learn of the more recent advances in the fields of pediatrics and obstetrics. In Michigan the cost from State tax funds for the undergraduate education of each physician is $3,000. They believe that a small annual expenditure to maintain the education of these physicians is a good investment.

Prenatal Care

Prenatal clinics conducted by local practicing physicians paid from maternal and child-health funds have been established in most of the States. Approximately 3,000 physicians are now paid from maternal and child-health funds for their services in these clinics. Several States have given these local physicians an opportunity to observe specialists conducting prenatal clinics and child-health conferences for several days. Many State health departments employ qualified obstetricians on a full-time or part-time basis to work at regular intervals with local physicians in the prenatal clinics. In Maryland two of the best-trained obstetricians in Baltimore are employed on a part-time basis by the State health department to visit the prenatal clinics throughout the State, to advise the local physicians conducting the clinics, and to give clinical consultation when necessary. Virginia has on the staff of the health department a full-time obstetrician who is continually travelling over the State to assist and advise the local physicians conducting the prenatal clinics. One of the prominent obstetricians in Birmingham, Ala., is employed on a part-time basis to assist in establishing prenatal clinics in Jefferson County, to visit the clinics conducted by the local physicians at regular intervals, and to consult with them concerning patients presenting unusual complications. These are but a few examples of how States are improving the quality of prenatal care.

The problem of continuity of care is one that has been found by the States to be difficult to meet, important as it is both in the maternity-care program and in the supervision of the health of children. Many prenatal clinics have no working relationship with a nearby hospital. No prenatal clinic can function satisfactorily without a cooperative agreement with a local hospital where complicated cases can be referred for care during pregnancy or at the time of delivery. Much of the value of prenatal care is lost unless good hospital care can be provided when necessary. In every prenatal clinic a system should be developed so that the patient's prenatal record is always made available to her attendant at the time of delivery, whether delivery is in the hospital or in the home. The number of patients to whom prenatal clinic care is provided has been increasing, but relatively few of the States or local communities have made any provision for these patients to obtain good medical care at the time of delivery. Continuous medical supervision of the maternity patients during pregnancy, at the time of delivery, and during the postpartum period should be the objective.

Obstetric Consultation

A few State health departments have provided funds to pay practicing obstetricians for clinical consultations on a fee basis. Although theoretically this would seem to be desirable and even greatly needed in certain areas of the country, in practice it is found that many general practitioners are reluctant to admit that they cannot safely handle any obstetric complication. There is also the fear that the patient will in the future seek obstetric care from the specialist.

Medical-Care Programs

In selected counties in Oklahoma, Louisiana, Utah, North Carolina, and Michigan, where patients formerly were unable to obtain competent medical care, the Children's Bureau has approved the expenditure of maternal and child-health funds to provide complete medical care (prenatal, delivery, and postpartum). Most of the States realize the need for providing complete medical care for such patients, but the present appropriations are wholly inadequate to provide this service.

Public-Health-Nursing Service

One of the most valuable services developed in recent years has been the extension of public-health-nursing service to include nursing assistance in the home at the time of delivery. Although in many areas where this service has been established it was at first frowned upon by the medical profession, it was soon accepted by them as one of the most valuable services offered by the public-health agencies. A trained nursing assistant with a package of sterile equipment, including caps, masks, gowns, drapes, gloves, basins, cotton, gauze, packing, and sometimes even drugs and instruments, as well as cord ties and material to care for the newborn child, makes the home deliveries far safer for the patient. The thousands of public-health nurses with their intimate contact with the patient and family in the home are rendering one of the most effective health services in the United States.

It would take hours to describe the hundreds of interesting types of service being provided to maternity patients throughout the United States. The variety of studies, surveys, and research projects would fill a book. The efforts to improve the quality of care rendered maternity patients in hospitals are of major importance at present.

These and many other Nation-wide efforts to improve the care of the maternity patient are effectual just as such efforts have proven to be in individual communities. A 14 per cent decrease in maternal mortality in the United States in 1937, a similar decrease indicated for 1938, as well as the significant decline in infant mortality, are concrete evidence of what is being accomplished. If the 1936 maternal mortality rate had remained unchanged in 1937 there would have been 1,746 more maternal deaths. If the 1936 rate had continued through 1938 there would have been 3,000 more maternal deaths than actually occurred in 1938. These are indeed encouraging reports.

Further improvement of maternal care in rural areas will depend largely on:

1. Continuing education of the public of the importance of good maternal care.

2. Providing competent medical care to the mothers now unable to obtain it.

3. Making hospitals with facilities for safely caring for obstetrical patients available in all areas.

* * *

ERRATA

The article on Sulfanilamide in Pediatrics by Grover Powers, M.D., appearing in the April, 1939 issue of the Journal, page 172, should be corrected as follows:—

Line 5, add to "erysipelas," "of the newborn."

Line 15, add to "fever," "influenza, or tuberculous meningitis."

Line 27, substitute "only" for "most."

In the dosage table all the minus should read ±, so that the table should appear

For children under 6 months—1.5±0.5 gr./lb.

For children over 6 months—1.25±0.25 gr./lb.

For children over 6 years—1.00±0.25 gr./lb.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES
for
PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

Therapeutic Aids in Otolaryngology*

FREDERICK N. SPERRY, M.D.,
New Haven, Conn.

When Dr. Ryder asked me to write a paper for this meeting the thought came that you might be interested in a few therapeutic suggestions which came from considering why the upper air passages are so frequently the location of symptoms of disease. To get a true picture all angles must be studies. It is for the purpose of developing some new angles without discarding any treatment of value that this paper is presented. If your thoughts can be turned from the surgical aspect of treatment to a consideration of the causes of disease and to the possibilities of relief by aiding nature in the processes of repair, my desire will have been accomplished.

About fifteen years ago Dr. J. A. Stucky of Kentucky read a paper at a meeting of the Triological Society detailing his work among the poor mountain whites. In this paper he linked the occurrence of many diseases to the poverty of the people. His treatment consisted largely of simple remedies and appropriate foods. Since that time he and others have presented papers on nose and throat conditions caused by food deficiencies and a group of our members, led by Dr. D. C. Jarvis of Vermont, have become deeply interested in searching for more exact knowledge of the causes, treatment and prevention of these conditions. In order to give this study a wide view, leaders in the field of Biochemistry are cooperating and some of the thoughts I am to present are from the writings of this group.

You may have read of experiments conducted by the manufacturers of Vigero, a plant fertilizer containing eleven elements. Twelve petunia plants started with apparently equal strength. The one given all eleven elements continued to thrive. Each of the others are deprived of a single different element. Some of them died and of those that lived each had marked defects. This illustration of growth and lack of growth in plant life is similar in some respects to what we find in our patients. Our patients require small quantities of vitamines and mineral foods. Perhaps they are necessary to activate the endocrine glands to produce the hormones which control cell activity or influence the autonomic nervous system.

We cannot hope to be cytologists, endocrinologists or specialists in the behavior of the autonomic nervous systen but we should recognize manifestations of dysfunction. Dysfunction of the endocrine glands and of the autonomic nervous system do produce symptoms in our fields. As rhinologists we have spread out before us the nasal mucous membrane which often shows dysfunction of the autonomic system.

In the large majority of individuals the nasal mucosa is a normal pink, but there may be marked variations in color and, if one has the habit of recording color, it is surprising how frequently it is found abnormal.

For many years I have noted the pale mucosa found in cases of hay fever and also in the presence of nasal polypi. Several years ago my attention was called to the fact that the color depends upon the action of the sympathetic and parasympathetic nerves. These parts of the antonomic system merit detailed consideration but here we can only refresh our memories with a few elementary facts. Omitting the metasympathetic which innervates viscera such as the heart having their own ganglionic centers, we have the remainder of the autonomic system divided into the sympathetic and parasympathetic. The sympathetic is connected with the cervical, dorsal and lumbar nerves while the parasympathetic has cranio-sacral anastomoses. With balanced action of the autonomic nerves we have health but with domination of one branch there are manifestations which show in the skin, mucous membranes, endocrine glands and other parts of the body. While not an accurate indicator of the action of nerves, the color of the nasal mucosa is a guide that if looked for cannot be missed.

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

For convenience we record the normal pink as zero, the red as one, two and three plus, the pale as one, two and three minus, three plus being bright red and three minus white. The red denotes a dominance of the sympathetic and among the symptoms the patient may show are nervous tension, high blood pressure, rapid pulse, high metabolic rate, warm extremities and a tendency to inflammatory attacks. The pale membrane denotes dominance of the parasympathetic and among the findings are debility, tired most of the time, cold extremities, low metabolic rate, low blood pressure, slow pulse, migraine, hay fever, asthma and other allergic symptoms. It is of interest to note that as a class allergic individuals are less subject to colds.

All patients do not fit into this classification for I have seen athletes with almost white mucous membranes, allergic patients with high pulse rate, and high metabolic rate associated with slow pulse. Among the questions to be solved are why patients with unstable autonomic nerves show these irregular manifestations and why they fluctuate as to classification. Perhaps it would be well to repeat that the autonomic system functions normally in most people and that most mucous membranes are pink.

Treatment of inflammatory conditions, especially head colds, should vary according to the nasal findings and systemic symptoms. From the many plans and therapeutic agents used for treatment in the presence of dysfunction of the autonomic nerves we shall have time today to consider only the use of two glandular preparations and two chemicals. Not even vitamines nor the usual treatment of the allergies, important as they are, can be considered. Insufficient experience prevents the including of potassium, which has been extolled recently for its value, in the treatment of hay fever.

Of late many papers have appeared in rhinological literature citing the use of insulin in non-diabetic cases. In nasal conditions with a dominant sympathetic, the red membrane, it is of aid in lessening the severity of the inflammatory invasion. Even with pink and pale membranes it is of some aid. In three unit doses daily or two or three times a week it stimulates the appetite and often gives the patient a feeling of well being. In an acute cold it may be the influence that halts the interference with nervous mechanism of the nose and turns the tide towards recovery.

The earliest reports on the use of insulin in small doses come from the writing of Dr. S. H. Beele, of Massachusetts. He has used three unit doses for over ten years and reports many spectacular cures of inflammatory conditions of the skin and mucous membranes in non-diabetic individuals.

During the past four years in my hands insulin has not given the brilliant results reported by Dr. Beele, but in cases of head colds and acute sinusitis it has been seemingly of great value. The absolute proof that any treatment has aborted an inflammatory invasion, of necessity, is lacking for there is always the thought that the cold might not have developed anyway but, when this happens frequently, it becomes at least circumstantial evidence.

In other hands insulin in small doses has been employed with much benefit for many conditions, mostly conditions affecting epithelial tissue.

Laboratory experiments on rats prove that insulin in doses comparable, according to weight, to three units in man has a marked effect in lessening oxygen metabolism. When given to patients with an oncoming head cold, insulin has a retarding or aborting effect similar to the influence of the derivatives of opium which also lessen oxygen metabolism. Another theory of the action of insulin in small doses is that it may have the so-called throw-back action that we are familiar with in the use of vaccines where, after the antigen is introduced, there is a negative phase, a let down. Then nature overneutralizes the antigen creating a surplus of antibodies. Another theory is that it acts as a catalist. Whatever the theory, in practice insulin is a help and might be tried in a wide variety of cases. Soon we may hope to learn its true value and its limitations.

The uses of epinephrin are too well known to be discussed here but there is another suprarenal preparation that merits consideration.

It was about five years ago that Dr. F. B. Blackmar of Georgia prepared a powder that is now marketed by Armour and Company under the name of Suprarenal Concentrate. It is composed of all of the suprarenal gland except epinephrin and is sold in two grain capsules. Its pharmacological properties are the same as those of the whole gland when given by mouth except the absence of pyloric spasm. Armour and Company market the whole gland also, and there are reports of its use but my experience has been with the Concentrate.

It is of service for patients with pale mucous membranes, especially those with hay fever. Three years ago I had six cases of hay fever that became symptom free using suprarenal concentrate alone. Two years ago the treatment was less successful but all of the patients were fairly comfortable. This past year, in addition to the concentrate, dilute hydrochloric acid was given and all of my fever cases were comfortable. In asthma and in other allergic conditions it is also of value. The beginning dose is one capsule after each meal, increasing if necessary to three after each meal. I know of no disagreeable effects but have not given larger amounts.

Of the chemicals affecting the color of the nasal mucosa, when administered internally, and therefore of service in the treatment of nasal conditions, iodine and sulfanilamide are helpful when the membrane is red and hydrochloric acid when the membrane is pale.

The cytologists tell us that the metals in the body exist in colloid form. The manufacturing chemists have seized this apparent fact and are marketing many colloid preparations. Just how much more useful iodine is in colloid form, I do not know, but I suspect it is a real improvement and am using the preparation known as Amends Solution. Five drops or less in a glassful of water an hour before meals is beneficial in conditions associated with red swollen turbinates and is also useful in the treatment of lymphoid hypertrophies. Iodine internally seems of much greater benefit than local treatment with silver albuminates or other antiseptics.

Dilute hydrochloric acid in five drop doses in a glassful of water an hour before meals appears to help hay fever and nasal hydrohoea. It seems foolish to put into a stomach that secretes an abundance of hydrochloric acid a few drops of that same acid. Several explanations have been offered to account for its action. They involve the same questions and theories that have been proposed in explaining its action when it is introduced into the blood stream. These theories are too controversal and the conclusions too uncertain for us to consider, but there can be no doubt that it is of benefit in appropriate cases. I have had a number of cases with so-called wet nose, using several handkerchiefs a day, become normal and remain so as long as they take five drops of dilute hydrochloric acid in a glassful of water an hour before meals. With this treatment we also have failures which probably means that as yet we do not know how to select our cases.

Therapy should be directed not only towards the relief of symtpoms but should attack the cause, and this brings us back to the beginning of our paper.

Recently I came across the statement known as Liebigs Law of the minimum. The law states "The body is regulated by the food least bountifully provided."

Our cells take from the surrounding fluids only such food as they need. There may be a superabundance of food but if some needful vitamine or metal is missing, the cells will not function normally. We are complex organisms needing food for energy and for tissue rebuilding which brings us to the thought that disease is often caused by food deficiency.

White flour and white sugar produce energy but, as the vitamines and minerals have been removed, are supposed to have no tissue rebuilding food value and we have some evidence of harmful effects. Dr. H. L. Stitt of Cincinnati, in a paper, stated that for a year at the Children's Hospital he deprived his patients, as far as possible of all refined carbohydrates. He and other pediatricians noted the great benefit of this routine. Many chronic discharging ears, antrums and ethmoid infections cleared up. Patient discharged did not return except when they digressed from the prescribed routine. No doubt most of you have noted the value of curtailing carbohydrates. One patient from whom I had taken refined carbohydrates because of sinus infection remarked "Its all my own fault. Every time I break over and eat sweets I get sinus trouble."

At present it is popular to condemn refined carbohydrates. Is this another food fad or is there something in it more than just common sense. Our patients with thick mucoid nasopharyngeal discharge often are relieved by dropping refined carbohydrates, but I am not sure as to whether it is because of less carbohydrate or less refined carbohydrate or because of the substitution of fresh vegetables and the minerals they contain.

There is seldom carbohydrate food deficiency but there is frequent need of the minerals that activate oxygen metabolism. The minerals are iodine, iron, copper, manganese and arsenic. Most of these are to be found in garden vegetables, cranberries, kelp, seafood, honey and other garden, orchard and dairy foods. It seems certain that foods as prepared by nature will fulfill the needs for metals better than given in medicinal form, but on this question laboratory work remains to be done.

Deficient diet, without doubt, causes many diseases. It may be, and indeed it is quite probable, that the inheriting of an unstable nervous system may be due to one or more generations of feeding on deficiency diets.

The United States Department of Agriculture investigated the "Diets of families of employed wage earners and clerical workers in cities" and found that in families of four members with an average annual income of $1200. only 1% had an adequate diet. When the income was $1800 9% were properly fed and when the income was $2800 23% had satisfactory food, showing how general the lack of knowledge as to feeding must be.

In this paper the lack of balance of the autonomic nervous system has been stressed but the chemical viewpoint is also important, especially the study of the hydrogen iron concentration in relation to disease. The biochemists are busy gathering knowledge for us to use clinically and we, as medical men, must be conversant with this scientific progress. The investigators of the endocrine glands and the autonomic nervous system are opening for us opportunities to recognize bio-chemical needs compelling us to view the patient as a whole. We may be specialists but this special knowledge should be grafted on our ever widening knowledge of general medicine.

THE CITY OF VILNA LOSES ITS RADIUM

(From the Special Correspondent of the Journal in London)

The fate of Vilna has been tragic. When the Russians first arrived there and before it was transferred to Lithuania, they insisted on buying most of the industrial equipment and movable material for Polish Zlotys, which are, of course, worthless. The Russians had their eye on the radium supply of the local cancer hospital and demanded it in exchange for Polish currency. The hospital authorities, anxious to retain it for their patients, explained that the existence of the hospital and the treatment of local sufferers depended on their keeping the radium, but this did not impress the Russians at all. They presented an ultimatum demanding its sale. The hospital authorities reluctantly agreed, provided it was paid for in dollars so that they could buy more. This the Russians refused, and eventually the hospital was obliged to give in, though they refused the Polish currency, the offering of which was an insult. Now the inhabitants of Vilna, thanks to the Russians, no longer have a fully equipped cancer hospital.

* * *

ANESTHETIC EXPLOSIONS RARE

Doctor Philip D. Woodbridge, a native of Connecticut and now associated with the Lahey Clinic, Boston, has supplied data from two and one-third million administrations of three explosive anesthetics to show that explosion hazards are negligible. The explosion mortality rates were too low to be figured from the data available, as reported in the Journal of the American Medical Association, since there were but two deaths in the entire series.

The PROFESSIONAL EQUIPMENT Co.
X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS.
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

Crystalline Zinc Insulin with Protamine

A Preliminary Note on a Newer Insulin Modification*†

BARNETT GREENHOUSE, M.D., F.A.C.P.
New Haven, Conn.‡

A variety of insulin combinations have been made possible by the addition of protamine (P), or zinc (Z), or both, to regular insulin. The various insulins mentioned here are referred to as regular insulin (RI), protamine insulin (PI),, zinc insulin (ZI), protamine zinc insulin (PZI) and a crystalline preparation, officially designated as "an insulin specially prepared as Solution of Zinc-Insulin Crystals", referred to briefly as "solution of zinc-insulin crystals" and to which we refer for convenience as "crystalline zinc insulin" (CZI). Thus graphically

$$\mathrm{RI} + \mathrm{P} = \mathrm{PI}$$

$$\mathrm{RI} + \mathrm{Z} = \mathrm{ZI}$$

$$\mathrm{ZI} + \mathrm{P} = \mathrm{PZI}$$

$$\mathrm{ZI\ Crystallization} = \mathrm{CZI}$$

The possibility suggested itself that since protamine zinc insulin is obtained from the combination of protamine with amorphous insulin impregnated with zinc, then the addition of protamine to crystalline zinc insulin should also produce protamine zinc insulin:

$$\mathrm{CZI} + \mathrm{P} = \mathrm{PZI}$$

In other words, crystalline zinc insulin might well be used as a base for protamine zinc insulin instead of regular insulin with zinc as is now used in the preparation of commercial protamine zinc insulin.

Accordingly, our newer insulin, "Crystalline Zinc Insulin with Protamine," is at present prepared by adding a suitably buffered sterile solution of protamine to a sterile solution of zinc-insulin crystals. One c.c. of this protamine buffer solution containing 2.5 mgm. protamine per c.c. added to 4 c.c. U-50 crystalline zinc insulin yields a U-40 dilution.[1] The resulting insulin is turbid and resembles commercial protamine zinc insulin in appearance. It is active, and seems to be at least as effective as the commercial protamine zinc insulin. We are using it now routinely and we have been able to substitute one for the other without loss of control of the diabetic state.

Theoretically, this insulin modification should retain the characteristics of the crystalline insulin for purity, low allergic properties and increased stability.

Clinically this insulin modification has so far been found to be non-allergic. Protamine zinc insulin has shown a surprisingly large number of local skin reactions with nodule formation, local redness and itching which make it undesirable or impossible to use in some cases. These reactions have not occurred with the use of the modified protamine zinc insulin.

CASE REPORTS

Case 1. — A man aged 49 was admitted to the Grace Hospital with a crushing injury to the right hand necessitating amputation of the right index finger. Postoperative urine specimens that day showed 4 + sugar and on the next morning his fasting blood sugar was 277 mgms. per 100 c.c. blood. The patient was not aware of having had diabetes previously and he presented no suggestive symptoms of it. There was no family history of diabetes. Aside from his injured hand physical examination was not remarkable except for evidence of a number of old injuries including a broken nose. His blood pressure was 134/80 and the oscillometric reading sof both lower extremities were satisfactory. He was slightly underweight. He was placed on a diet of C 150, P 70, F 135 with an initial dose of crystalline zinc insulin, decreasing doses of protamine zinc insulin together with regular insulin as indicated to further control glycosuria.

---

[1] Similarly, one c. c. protamine buffer solution containing 5 mg. protamine per c. c. added to 4 c. c. U-100 Solution of Zinc-Insulin Crystals yields a U-80 dilution of the modified protamine zinc insulin.

[2] The zinc content of the herein described modified protamine zinc insulin is approximately ten to five times less than that of commercial protamine zinc insulin.

*Read in part before the The New Haven Medical Association, November 16, 1938.

†From the Metabolic Service and Diabetic Clinic of the Grace Hospital.

‡Attending in Metabolism, Grace Hospital, New Haven.

Throughout the hospital stay he complained constantly of itching and painful lumps in his arms and legs wherever the protamine zinc insulin was injected. Urticaria in varying degrees was always present at the site of injection and of sufficient intensity to keep him uncomfortable during the day and disturb his sleep at night. On the second day of protamine insulin therapy his entire left arm was covered with giant wheals. No local reactions were caused by either the crystalline or regular insulin.

The wound was healing well and he was discharged after ten days on the same diet with 20 units protamine zinc insulin which had kept him sugar-free with a flat blood sugar curve varying during the day from 100 to 150 mgm. per cent.

TABLE 1. — Diabetic Chart of Case 1

Date	Hour	URINE S	A	D	B. S.	Insulin	Diet	Remarks
10-25-38	7	4+	0	0			C 150	Urine: acid, spg. 1080, alb. 2+, many wbc, few rbc, no casts.
	11						P 70	
	4	4+	0	0			F 135	
	9							
10-26	7	4+	0	0	277		Divided	Blood: hb 95%
	11						B 1/5	rbc 5.190, wbc 12,600
	4					(20)	D 2/5	P 78 (non seg 6, seg 72)
	9						S 2/5	Sm 14, Lm 17, E 1.
10-27	7	4+	0	0		[35] + 15		Kahn negative.
	11	4+	0	0		20		
	4	0	0	0				
	9	0	0	0				
10-28	7	0	0	0	200	[35] + 15		Complaint of painful lump with itching at site of insulin injection
	11	0	0	0				
	4	2+	+	0				
	9	2+						
10-29	7	4+	0	0		[30]		Urticaria entire left arm
	11	0	0	0				
	4	0	0	0				
	9	0	0	0				
10-30	7	0	0	0		[20]		Local skin reaction.
	11	4+	0	0				
	4	3+	0	0				
	9	0	0	0				
10-31	7	0	0	0		[20]		Local skin reaction.
	11	+	0	0				
	4	0	0	0				
	9	0	0	0				
11-1	7	0	0	0				
	9	0	0	0	143	[20]		Local skin reaction.
	11	0	0	0				
	4	0	0	0				
	9	0	0	0				
11-2	7	0	0	0		[20]		Local skin reaction.
	9	0	0	0	100			
	10:30	0	0	0	120			
	11:30	0	0	0	100			
	4:30	0	0	0	150			

The following symbols designate the type of insulin used:
[20] Protamine Zinc Insulin; (20) Crystalline Zinc Insulin; 20 Regular Insulin.

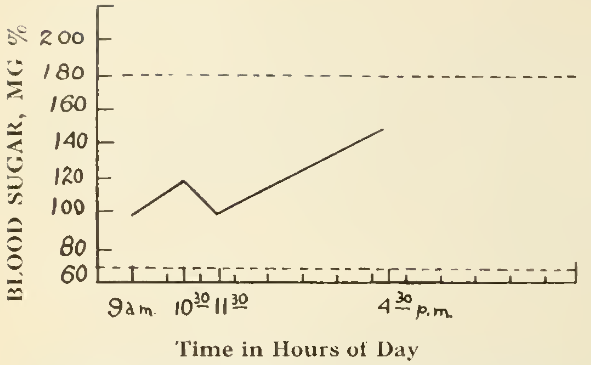


CHART 1. Blood sugar curve in Case 1 on diet of C 150, P 70, F 35, with 20 units protamine zinc insulin.

Two weeks later he still displayed local skin reactions. He was then changed over to crystalline zinc insulin with protamine and all reactions ceased. There were no further general or local manifestations until one week later when evidence of sensitivity recurred when commercial protamine zinc insulin was again tried, to disappear once more when the modified protamine zinc insulin was again administered. During its use for a total period of about a month the modified insulin was effective in keeping the diabetes under good control.

Case 2. — Mrs. S. C., age 44 had had diabetes for seven years. She had been on insulin for several months about five years ago and then discontinued. About two years ago she was first admitted to the hospital for stabilization on protamine zinc insulin. Her physical examination was negative except for trichomonas vaginalis. She was 15 lbs. overweight, very nervous and sensitive to pain. Her diabetes was easily controlled in five days and she was discharged on a diet of C 150, P 75, F 75 with 25 units protamine zinc insulin. The blood sugar curve was within normal limits, ranging from 95 to 180 mgm. per cent. and she was sugar-free except for a 3 + sugar on a fresh specimen at a blood sugar level of 180. (Normoglycemic glycosuria occurred here again on two occasions subsequently).

Ten days after discharge from hospital she developed a generalized urticaria which was especially marked at the points of injection of both protamine and regular insulin. Change of brands of insulin brought no relief. The patient abandoned protamine zinc insulin and returned to the use of regular insulin. The generalized urticaria subsided but she continued to show local reactions to the regular insulin.

After a lapse of 20 months the patient returned complaining of dizziness, loss of menses and nervousness. She had gained weight from overeating and had been taking 15 units regular insulin daily. The blood sugar

TABLE 2 — Diabetic Chart of Case 2

		URINE						
Date	Hour	S	A	D	B. S.	Insulin	Diet	Remarks
8-30-37	11	4+	0	0	250	[30] + 20	C 150	Urine: acid, sp.g. 1010
	4	4+	0	0		15	P 75	alb. +, full of epith.
	7	0	0	0			F 75	cells, occ. wbc.
8-31	7	4+	0	0	217	[30] + 20		Blood: hb. 75%
	11	3+	0	0				rbc 4,860,000
	4	+	0	0		5		wbc 10,400
	9	0	0	0				Wass. neg.
								NPN 34
9-1	7	0	0	0		[35] + 20		Insulin reaction 2:30
	11	4+	0	0		10		p.m.; 200 c.c. orange
	4	0	0	0				juice, 1 lump sugar.
	11	+	0	0				
9-2	7	+	0	0		[35] + 15		
	11	3+	0	0				
	12	0	0	0	110			
	4	0	0	0				
9-3	7	0	0	0				
	8	0	0	0	169	[30] + 10		
	10:30	3+	0	0	180			
	11:30	+	0	0	125			
	4	0	0	0	95			
	9	+	0	0	125			
9-4	7	0	0	0		[30] + 5		

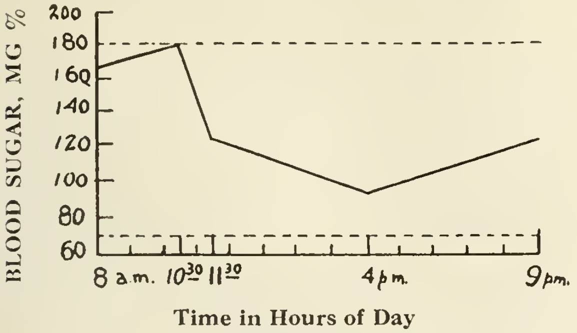


CHART 2. Blood sugar curve in Case 2 on diet of C 150, P 75, F 75, with 30 units protamine zinc insulin and 10 units regular insulin.

was 280 and the urine showed a complete reduction. She was again hospitalized for the expressed purpose of using crystalline zinc insulin with protamine. For the first three days, however, she was given commercial protamine zinc insulin to demonstrate that her sensitivity to it still persisted and then it was replaced by the modified protamine zinc insulin which showed no local skin reaction and which she tolerated without any pain. The patient is continuing the use of this modified product and is under excellent control, being mostly sugar-free on 20 units with random blood sugars of 168 and 156.

These evidences of skin sensitivity to protamine zinc insulin usually occur in the first few weeks of protamine insulin therapy and then usually disappear. They are caused presumably by the presence of a double foreign protein, one derived from the protamine and the other from the insulin solution itself. But in using crystalline insulin as a base for protamine zinc insulin this insulin foreign protein is eliminated through crystallization leaving only the protein factor of the protamine which in itself has a normal allergic incidence and thus reduces the sensitivity to a minimum. Sensitivity to the insulin molecule itself has been reported but this possibility must exist in any type insulin.

Because of its purity, crystalline insulin has been indicated for those who develop areas of lipodystrophy at the site of injection on regular or protamine zinc insulin. Furthermore, since

TABLE 3. — Diabetic Chart of Case 2

		URINE						
Date	Hour	S	A	D	B. S.	Insulin	Diet	Remarks
5-15-39	11	4+	0	0	280	[50] + 30	C 150	Blood: hb. 75%
	2	2+	0	0			P 70	rbc 4,810,000
	4	+	0	0			F 70	wbc 12,000
	9	0	0	0				P 69 (non seg 3, seg 66)
								Sm 24 Lm 7
5-16	7	0	0	0	185	[50] + 10		Complaining of painful lump at site of injection
	11	+	0	0				
	4	0	0	0				
	9	+	0	0				
5-17	7	+	0	0	120	[40]		Painful lump persisting; now also complaining of pain at site of second injection
	11	0	0	0				
	4	0	0	0				
	9	0	0	0				
5-18	7	0	0	0		[(30)]*		Pain persisting at previous site of injection. No local reaction or pain with injection of modified protamine zinc insulin.
	11	0	0	0	145			
	4	+	0	0				
	9	+	0	0				
5-19	7	0	0	0		[(20)]		No local reactions or complaints.
	11	+	0	0				
	4	2+	0	0				
	9	4+	0	0				
5-20	7	0				[(20)]		No complaints
	11	4+						BP 142/84

*[(20)] Crystalline Zinc Insulin with Protamine

sensitivity to insulin reduces its effectiveness, calling for excess dosage and delaying stabilization, it may be anticipated that our modification should permit normal insulin effect. The presence of zinc increases the stability of crystalline insulin, at least it is more heat resistant; and in view of this the possibility of a more stable protamine insulin presents itself for consideration. Further consideration is also indicated of the optimal zinc content since crystalline zinc insulin as now available has a lower zinc content than has commercial protamine zinc insulin.[2]

These theoretical considerations merit investigation. At the moment we are impressed with the observations that our modified protamine zinc insulin is clinically identical with the commercial protamine zinc insulin in effectiveness and that we have encountered no allergic manifestations in its use.

Until such time as crystalline zinc insulin with its cumbersome official designation can be better named, we are reservedly referring to our insulin modification as "Crystalline Zinc Insulin with Protamine."

Summary

"Crystalline Zinc Insulin with Protamine", a newer insulin modification is presented. It is a modified protamine zinc insulin in which the protamine is combined with a solution of zinc insulin crystals as a base instead of the amorphous insulin with zinc as in the commercial protamine zinc insulin. The modified preparation is clinically identical with the commercial product both in appearance and effect, but is superior to the latter in that it is less allergic than the protamine zinc insulin now available commercially.

107 Whitney Avenue.

Solution of Zinc-Insulin Crystals with a zinc content of from 0.2 to 0.4 mg. zinc per 1,000 units was specially prepared by Frederick Stearns and Co. as U-50 and U-100 in accordance with the present specifications of the Insulin Committee for Solution of Zinc-Insulin Crystals. The Protamine was supplied by Eli Lilly and Co. and E. R. Squibb and Sons, to give a content of 10 to 12.5 mg. protamine per 1,000 units of Crystalline Zinc Insulin with Protamine.

NATIONAL CONFERENCE ON MEDICAL SERVICE

The National Conference on Medical Service (formerly Northwest Regional Conference) will hold its 14th Annual Meeting at the Palmer House, Chicago, Sunday, February 11 at 10.00 a.m. The program will afford an opportunity for physicians throughout the United States to exchange ideas and obtain sound practical information on medical economics for the good of the profession and the public.

On the program are found the following: Round table discussion on "Group Medical Care and Group Hospitalization Programs" by several leaders in this field. "Allocation of Federal Funds to States" presented by Doctor Leland of the A. M. A. Bureau of Medical Economics. "Effective Public Relations" discussed by Doctor Fishbein and Doctor E. J. McCormick of Toledo. Round table discussion on "Medical Welfare Programs" by several leaders in this field including our own State Society Secretary, Doctor Barker. Paul G. Hoffman, President of the Studebaker Corporation, will be guest speaker at the noon-day dinner meeting.

All members of the A. M. A. are cordially invited to attend the Conference. No registration fee or dues.

* * *

DANGER OF WILLETT'S FORCEPS

In Great Britain Willett's forceps has been extensively used for traction on the fetal scalp in placenta praevia. Professor F. J. Browne reports a drop in fetal mortality with the use of the forceps from 54.2 per cent to 46.4 per cent. In the Journal of the American Medical Association this same writer, however, reports two cases in which the use of Willett's forceps was followed by Bacillus welchii infection of mother and fetus. A lacerated wound of the scalp is necessarily made in applying the forceps, the maternal and the fetal circulation of the placenta are arrested by the compression produced by the attached weight often killing the fetus, thus producing an ideal condition for infection by the Welch bacillus — a ragged wound in dead tissues. Professor Browne now concludes that Willett's forceps has no place in the treatment of placenta praevia.

Vitamin Deficiencies with Special Reference to Those Involving the Nervous System*

EDWIN F. GILDEA, M.D.,
New Haven, Conn.**

The factors which make possible the common occurrence of states of dietary deficiency, in a region where the supplies of food are ample and varied, are complex and obscure. Their ramifications lead into the social, cultural, economic, and psychological fields, as well as the pathological and biochemical disciplines which are more commonly accepted as the domain of medicine.

Man has always recognized that his health depended on the kind of food he ate. But he has tended to approach this problem in much the same fashion as he has his mental and sexual activities. He has paid more attention to the rules of his religion or tribal leaders than to those of the recently evolved scientific doctors of medicine. In fact until quite recently the doctors themselves have behaved toward food in a manner similar to that of their lay brothers. One need only mention the proscription of pork by the Hebrews, the fasts of the Roman Catholics, the special customs of the Hindus, and finally our modern fads of vegetarianism, Hay diets, etc., etc., to establish this point. As in the case of sex, man's emotions, his fears and superstitions, are so closely linked with food and particularly his appetite for food, that he has found it impossible to approach these problems in a scientific fashion. Even today the wealth of clinical psychopathological material indicating the intimate if complex relationship between oral, anal and erotic activities is ignored or rejected by most physicians. In addition to the inner individual problems of appetitie, the kind and amount of food a man eats are dependent on the interplay between constitutional and cultural factors. Even in a region like the northern U. S. where food is plentiful, social as well as economic status determine the basic diet. Curiously enough high economic status does not necessarily mean an optimum diet because special fashions enter the picture and limit the diet. For example extremely refined diets with fancy candies, pure white bread and lean meat are popular with the well-to-do and yet are low in vitamins.

A brief resume of the story of pellagra will serve to illustrate many of the conditions which retarded our understanding of deficiency diseases. The setting of the modern story is in the south but much of our scientific information on pellagra was acquired by physicians from the north and from Europe. These outsiders have found it easier to see the defects in dietary customs than they would have if they had made similar studies in their own homes.

As in the case of so many of our other modern discoveries, the answer was found years ago but was neglected. In 1707 Pedro Casal[1] reported that improvement in diet relieved the symptoms of pellagra. Again 80 years ago Lussana and Frua reduced mortality from pellagra in a group of patients from 24% to 4% by improving diet. But toxins and infections were then important interests of medicine and diet was neglected. Goldberger[1, 5] between 1916 and 1920 demonstrated in a most clearcut fashion that pellagra could be produced by subsistence on certain diets that were common in the south. He was also able to produce with deficient diets a condition known as black tongue in dogs which resembled pellagra in some respects. And finally he demonstrated in a large scale experiment in a state institution that the addition of a little milk and some fresh vegetables to the diet would prevent the occurrence of pellagra.[5]

Not a great deal of attention was paid to this work by southern physicians, and in spite of an increasing bulk of experimental and clinical literature confirming Goldberger, little progress was made. Many physicians continued to report at medical meetings that infections, toxins, etc. were the primary cause of pellagra, thereby arousing controversies. Dr. Spies, one of the more zealous and articulate of the proponents of the deficiency hypothesis, finally found an eminent southern physician, Dr. McLester, who offered to assist him in conducting a dramatic and convincing experiment. McLester, an authority on dietetics who had had a wide experience with pellagra in Alabama and was on the visiting staff of an institution where the incidence and mortality of pellagra were high, set up the experiment as he desired. He chose 50 extremely sick pellagra patients, most of whom he knew from experience were sure to die even when placed on a well balanced and adequate diet. Spies[6] treated these patients with a balanced high caloric and vitamin diet supplemented with 200 gms. of Brewer's yeast powder. 8 patients who could not swallow due to mouth lesions were given intravenous liver extract (Parke Davis). All but 3 patients recovered completely. The 3 who died had practically recovered from the pellagra before expiring of complicating disorders; the first of pneumonia, second of an embolus, and the third following an operation for intestinal obstruction. McLester and his associates were impressed by these results and have contributed much since then toward furthering the dietary treatment of pellagra. There remain, however, throughout the country numerous physicians who are still not convinced, or have neglected these demonstrations in the etiology of pellagra. Even with this evidence at hand progress in improving southern dietary conditions remains slow. The people don't like other kinds of food and they are suspicious of and resent outside interference. The story of pellagra illustrates the retarding influences of cultural lag, man's inability to criticize or change his dietary habits and his resentfulness and distrust of outsiders who try to improve him. The story of beriberi is much the same.

---

*Portions of material included herein were presented at both the 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26 and the 15th Clinical Congress, New Haven, Sept. 19-21, 1939.

**From the Department of Psychiatry and Mental Hygiene, Yale University School of Medicine.

If there remains skepticism with regard to the origins of the extreme forms of deficiency such as pellagra, beriberi, and the like, the more obscure and subtle manifestations of deficiency diseases are even more neglected.

Strauss and also Weiss in Boston, Jolliffe in N.Y., Cowgill[2, 7] in New Haven, and Lewy now in Philadelphia[3] have described some of these less obvious conditions. It is particularly important for physicians to realize that even in the communities where the knowledge of the importance of deficient diets is widespread, these conditions persist. This is due in some instances to economic stress but more frequently to cultural habits of eating.

The fact that the southern diet of corn and pork fat is readily recognized as peculiar and deficient by the northerner but that the common diet of well-to-do families frequently approaches a borderline degree of deficiency is as difficult for us to recognize and believe as it is in the case of the southerners. This situation has arisen as a result of the increasing refinement of and cooking of foods. For example most flours are refined until the breads that used to furnish basic quantities of B vitamins are now almost devoid of vitamins. In addition the increased use of candy furnishes large amounts of calories without adding vitamins. Furthermore, many people prefer only lean meat and the organs, liver, kidneys, marrow, stomach, etc. are considered too crude to eat. Thus the vitamins have to be supplied by the bulky vegetables. These amounts of vitamins are adequate for ordinary life only. But under any increased requirement such as violent physical activity, fever, pregnancy, etc., these diets may prove inadequate and the symptoms of deficiency may supervene.

At this point an outline of the complex conditions which may lead to deficiency diseases will serve to simplify the subsequent discussion of vitamins and their relation to nervous system disorders.

Outline of Factors Leading to Deficiency Diseases:

I. Failure to ingest a well balanced diet, i.e. the daily ingestion of meats, (including occasionally liver or kidneys), milk and eggs, fresh vegetables, fruit and cereals and breads containing some of the grain germ layers. Failure may be due to:

1. Limited economic status.
2. Social customs.
   e g. corn and pork diet of south; potato, candy and lean meat in north; poorly organized vegetarian diets, Hay diets; other

fads such as extreme weight reduction, etc.

3. Ill-advised proscriptions of physicians.
4. Personality determined aversions or idiosyncrasies toward food.
   a. the ascetic who looks on food as a manifestation of spiritual weakness.
   b. the hypochondriac who gives up one food after another because of symptoms.
   c. the hysterical person who uses refusal to eat customary food for ulterior but usually unconscious purposes.
   d. other mental disorders.
5. Practically all illnesses if severe enough may prevent the ingestion of a well balanced diet.

II. Disturbed absorption due to nausea, vomiting, chronic diarrhea of all kinds, and lesions producing obstruction.

III. Lack of substances in stomach or intestines may prevent utilization of vitamins, as for example the lack of intrinsic factor of Castle results in pernicious anemia.

IV. Individual requirements may be high.

V. Constitutionally people differ markedly in the amount of vitamins necessary to prevent symptoms. Sources of these differences are unknown.

VI. All conditions which increase metabolism increase vitamin requirements.

Increase in caloric intake, particularly when in form of carbohydrates increases vitamin requirements. Growth, pregnancy, fever, hyperthyroidism are common examples of conditions which elevate food and vitamin requirements.

VII. That the ingestion of certain *toxic substances* may increase vitamin requirements has been demonstrated recently.

Alcoholic beverages can be tolerated in larger quantities if additional B vitamins are given than without[7].

The same situation has been reported as pertaining to lead, arsphenamine, and sulfanilamide. There is some justification for concluding that the same situation exists in the case of other drugs and toxins.

At the present time lack of the B vitamins may be considered as playing the primary role in various forms of nervous system disorders such as beriberi, polyneuritis, Korsakoff syndromes, and pellagra, etc. While there is a possibility that vitamin A may also play a role in preventing nervous system lesions, its place has not been clearly defined.

Today it is known that all the B vitamins may be found in relatively large amounts in Brewer's yeast, polishings of grains particularly rice and wheat, and in liver.

By 1897 what is now called B complex was recognized by a few workers as responsible for the prevention of beriberi. But it was not until 1916 that sufficient progress had taken place in the isolation of active material to make possible the demonstration that there were several fractions with special properties. Goldberger recognized a PP fraction that would prevent pellagra. Then there was the Beriberi preventive factor, etc.

In 1926 the thermolabile and thermostable fractions were recognized. Since that time progress has been extremely rapid.

The thermolabile fraction was found to have the antineuritic qualities. This factor was isolated in 1926 and synthesized in 1936 as thiamin. There also are other fractions that promote growth known as B_3 and B_4 and W.

The thermostable fraction proved to contain the pellagra preventive factor. In 1933 riboflavin was isolated and then synthesized in 1935.

Nicotinic acid was isolated in 1937 and almost immediately shown to relieve the skin lesions in pellagra.

There remain, however, unknown fractions that may be necessary in the maintenance of the nervous system.

There remain also the extrinsic and intrinsic factors of Castle and choline that may play a role in nervous tissue metabolism as well as in pernicious anemia and in fat metabolism.

With this résumé of the present situation in mind we can turn to the practical problem of recognition of the early symptoms of deficiencies. Lack of these substances disturbs the functions of the whole body. The earliest symptom may be only loss of appetite or lack of pep.

Then one or more of the following systems will break down:

1. Skin may show slight atrophy, scaling, pigmentation and if not treated progress to ulceration.

2. Nervous system. These symptoms begin as paresthesias and pain and are followed by

weakness and paralysis. Mental disturbances are not uncommon.

3. Alimentary tract. Anorexia and stomatitis are the first symptoms; these may be followed by: Atrophy of the tongue, achlorhydria, and diarrhea. Ulceration of the intestine may develop in severe cases.

4. Hematopoetic system may be the one first affected.

Macrocytic or microcytic or hypochromic anemia may develop, depending on the kind of deficiency and on the patient.

5. Cardiovascular. Irregularities or rapid pulse rates constitute early signs of vagus nerve involvement.

6. Disturbed carbohydrate metabolism may produce ketosis and phenylpyruvic acid in the urine.

This latter early sign is now thought to be the fundamental clue to the seat of action of B^1 or thiamin. The present conception is that B^1 is necessary in the metabolism of carbohydrates. It apparently serves as a coenzyme in the disposal of pyruvic acid and indirectly of lactic acid.

The conception that B_1 is essential to carbohydrate metabolism would account for the protean manifestations of B_1 deficiency. In fact if the above hypothesis is true it is surprising that so many specific syndromes have been made out. However, the common involvement of the nervous system could readily be explained by its well known sensitiveness to any reduction in available glucose.

From the clinician's point of view it is particularly important to recognize that the early symptoms of lack of pep and paresthesias and weakness may persist for years before some added demand such as fever, pregnancy, alcohol ingestion, etc., will suddenly produce the severe symptoms that may be readily recognized.

On the other hand only a modest percentage of patients have the symptoms of lack of pep and paresthesias on the basis of a vitamin deficiency. As it subjects patients to unnecessary expense to give unnecessary vitamins and may possibly be harmful, it is important not to err in the opposite direction. And this is easy to do because the emotional and cultural factors which kept us from recognizing deficiency diseases can lead to the opposite extremes. Therefore we must be on the lookout for all the possible early signs which may help in diagnosis. Eventually of course it will be possible to make quantitative estimates of body vitamins and this will simplify the diagnostic problem.

There are many of these early signs and they refer to different systems. Only a few can be mentioned here.

The tongue is particularly important and frequently gives an early clue. The tendency to beefy redness may be all that is noticeable or there may be some atrophy of papillae. Again there may be fissures and the beginnings of the geographic tongue seen in pernicious anemia.

Slight scaling of skin on exposed areas and pigmentation is a clue worth looking for. On the other hand slight cardiac irregularities and tachycardia may be the first sign of the beginnings of a syndrome due to vitamin deficiency.

In other patients only the nervous system may be involved. Usually paresthesias and pain in hands and feet are complained of but there are occasional patients who merely become weak and apathetic and gradually go downhill with muscle weakness and no localized neurological signs.

Quite recently Lewy and others have pointed out that a severe ketosis with or without the finding of phenylpyruvic acid in the urine frequently indicates a B_1 deficiency.

Of further aid in diagnosis is the therapeutic test. Unfortunately these deficiencies occur rarely in only one factor. For this reason only partial improvement may be obtained with one vitamin fraction.

For the present it is relatively simple to rule out B_1 with intramuscular thiamin. Such symptoms as the peripheral neuritis and cardiac irregularities and poor appetite should be improved in 3-5 days by thiamin injected i.m. in 20-50 mgm. doses daily. Skin and tongue lesions should respond in a few days to nicotinic acid.

It should not be forgotten, however, that there are many other vitamin-like factors essential for the normal metabolism of nervous and other tissues. For example, the intrinsic factor of Castle prevents pernicious anemia and combined system disease. For this reason all patients whose symptoms are attributable to vitamin deficiency and who do not respond to B_1 and nicotinc acid should be placed on a well balanced diet supplemented by liver extract in large doses (5-10 ml. daily of dilute liver extract by intramuscular injection), before one can be sure that the symptoms are not due to a deficiency of some sort.

Failure to do this has led to reports that combined system disease is not relieved or arrested by liver therapy, that pellagra is not due to a dietary deficiency, etc., etc.

The above remarks are more illustrative than in any way a complete discussion of any of the questions that have been raised. They should serve to bring out, however, that the origins of deficiency diseases are as much cultural, social and psychological as they are medical, metabolic and chemical. The recognition, treatment and prevention involves the utilization of contributions from all of these fields.

REFERENCES

Relatively complete bibliographies may be found in numerous works. The following will be found particularly useful:

1. Browning, Ethel, The Vitamins, London and Baltimore, Williams and Wilkins Co. 1931.
2. Cowgill, G.R., The Vitamin B Requirement of Man, New Haven, Yale University Press, 1934.
3. Lewy, F.H., Vitamin B. Deficiency and Nervous Diseases, J. Nerv. and Ment. Dis., 89: 1-25 and 174-203, 1939.
4. Williams, R.R., and Spies, T.D., Vitamin B_1 and Its Use in Medicine, MacMillan Co. N.Y. 1938.
5. Goldberger, J., Pellagra, Its Nature and Prevention, Wash. Pub. Health Rep., 42:2193-2198, 1927.
6. Spies, T.D., Chinn, A.B., and McLester, J.B., Severe Endemic Pellagra, J.A.M.A., 108: 853-857, 1937.
7. New Series of Articles on Vitamins, J.A.M.A., 110:577 and continuing into Vol. 3, 1938.

* * *

REPORT ON TUBERCULIN TESTS IN MIDDLETOWN

M. L. Palmieri, M.D., M.P.H., Middletown, Conn.[*]

During November 254 adolescent boys and girls were tested with Tuberculin (P.P.D.). Three groups were included in the total number. They consisted of the second year pupils in Woodrow Wilson High School, Middletown High School and the local National Youth Administration employees. Tabulation of individuals who underwent the test is as follows:

NYA	WHS	MHS	TOTAL
47	59	142	254

The number of positive reactors and percentage of positives in each group are tabulated as follows:

NYA	WHS	MHS	TOTAL	
19	7	37	63	Total number
40	12	26	25	% of total

The range of age in the combined groups is 14 to 26 years and the average age for each individual group is as follows:

NYA	WHS	MHS
20	15	15

Middletown High School serves the area known as the First Taxing District, which is a rather densely populated section of the city. Wilson High School draws its students from the Second Taxing District, which is that territory surrounding the periphery of the First and is less densely populated.

Although the average age of the pupils in the two high schools is the same, the chief factor which causes a greater percentage of positive reactors in the MHS group is probably attributable to the more crowded conditions under which the latter group lives. The NYA has one factor in common with the MHS group and that is that the bulk of the group live in the First Taxing District. It is also an older age group and the fact that they are employed on NYA shows that most of them are from families in the low income bracket in which the standard of living is not of the best.

The group received x-ray studies of the chest thus:

NYA — 15 of 19 pos.
WHS — 5 of 7 pos.
MHS — 27 of 37 pos.
TOTAL — 47

In all subjects except two, x-ray revealed healed tuberculous infection of the childhood type with calcification either of tuberculous lymph nodes at the root of the lungs or in the lung tissue or both. Two students showed suspicious lesions and they are being investigated further. The public health nurses will visit the home of positive reactors and urge other family members to have check-up examinations with their family physicians.

* * *

You can't treat tuberculosis until you find it.

---

[*] Health Officer, Middletown

Controlled Physically Induced Fever,

A Safe and Valuable Addition to Therapeutics*

WILLIAM BENHAM SNOW, M.D.**
New York City

'Fever Therapy in neurosyphilis,' as stated in a recent article by Prof. Tracy Putnam, 'has a long history in the life of one man — Wagner von Jauregg'.[1] To this one individual, von Jauregg, modern medicine owes a great deal, for it is through his researches with the use of old Tuberculine in 1891,[2] and later the induction of Malarial Paroxysms in the treatment of Paresis (1918),[3] that the stimulus is due which has resulted in the last eight years of consistent painstaking research in modern Controlled Physically Induced Fever.

The use of radio currents by Dr. Carpenter[4] of the General Electric Company in 1930 stimulated interest in early workers. Later, Mr. Kettering[5] of the Research Division of General Motors Company for several years graciously contributed of his time, energy and finances to further researches in fever therapy.

Many patients were treated by various methods of physical induction from the use of long wave diathermy, hot boxes of various kinds, Radiothermy, hot water baths and air-conditioned cabinets mainly at low humidities, and various combinations of each.

Limited researches were made, but until the First International Fever Conference held in New York City in 1937[6], the medical world was not fully awakened to the real possibilities of Physically Induced Fever as a therapeutic agent. This conference, which was held conjointly as the Sixth National Fever Conference, brought us all a realization of the fundamental needs in both apparatus and technic toward making fever therapy less of a torture, more comfortable and safer to patients.

As in the development of all evolutionary machinery, we have seen a gradual and convergent trend in manufacture of equipment for fever therapy. At present, all modern forms of commercially produced equipment supply humidities of 85% to 100%, and often combine in such apparatus some arrangment for combined treatment with Short Wave induction. The elevation of humidity in cabinets for fever therapy has been the most important factor contributing to both added comfort of the patient and to his safety. At high humidities we are able to get elevation of temperature in patients with much lower cabinet temperatures than otherwise possible. This is due to increased conductivity[7] of the skin under humid atmospheric conditions, and diminished evaporation through sweating. Needs for sweating are diminished in highly humidified environment.

It is most desirable in this respect that air motion be at a minimum. Cabinets will be most efficient if the humid atmosphere envelops the patient with but the slightest of convection currents. The use of fans to bring humidity into the patient's chamber is undesirable due to air motion increasing evaporation and heat loss.

It is always to be borne in mind that by physical methods of fever induction, we are constantly combating the physiological efforts on the part of the patient's organism to dissipate heat. Ideally, the cabinet should be well insulated to prevent loss of heat from the chamber. The better this insulation, and the less movement there is of damp air in the cabinet, the less additional heat must be supplied to the cabinet for induction and maintenance of fever.

Other requirements in cabinets are:

Ease of accessibility to patients, regardless of size, at all times and from all directions.

Roominess within the cabinet promotes ease of nursing of the patient, and additional freedom of movement to the patient.

---

*Read before the Connecticut Physical Therapy Society at the 147th Annual Meeting of the Connecticut State Medical Society, New Haven, May 26, 1939.

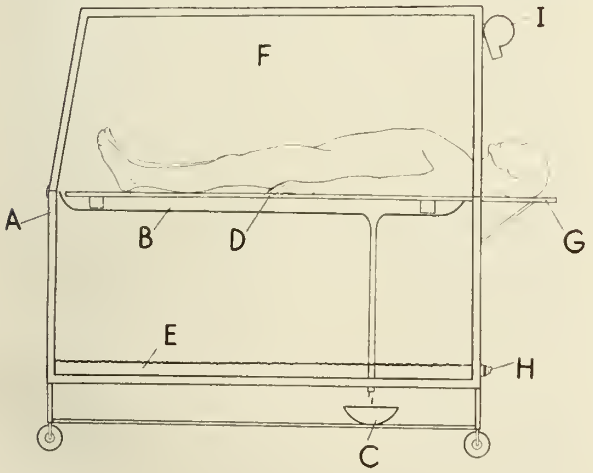
**Associate in Medicine. College of Physicians and Surgeons, Columbia University, New York City; Director of Physical Therapy, Columbia-Presbyterian Medical Center, New York City.

Means should be provided for rapid egress of the hot air from about the patient without throwing the entire apparatus open.

A bar for the patient to grasp in changing position or exercising his arms is a worthwhile refinement.

Cabinets with high humidities, and which are well insulated, should carry the patient's prescribed fever plateau at cabinet temperatures of no more than 5° above that of the temperature of the patient.

SCHEMATIC HIGHLY HUMIDIFIED FEVER CABINET



A—Insulation completely surrounding the chamber.

B—Pan in which fluids from patient's body are drained.

C—Pan to collect patient's drainage.

D—Rack on which patient lies.

E—Water with large evaporating surface of entire floor of apparatus heated to necessary temperature,

ONLY. 130°F. during period of elevation.
120°F. during period of maintenance.

F—Upper chamber highly humidified:
Maximum during induction — 122°F.
Maintenance temperature 3° — 5°F. above the patient's temperature.

G—Headrest.

H—Silent switches to control heating of the water.

I—Air blowers to cool head of patient.

DOORS—10 inches high provide access to patient full length of the cabinet.

SIDE LOADING for either side is provided — an important item in handling of patients at termination of the treatment, without a movable stretcher.

Entire apparatus functions independent of water supply and operates on a 30 ampere outlet, and is mobile.

Such an apparatus does not require the use of short wave induction to augment temperature elevation. Short wave seems unnecessary and perhaps undesirable. There is no advantage in decreasing the time for induction of Fever in patients as obtainable by simple humidified cabinets. There is a definite time necessary for patients' physiology to adjust itself to the rude insult of heat induction. The embarrassment to patients in the induction period makes this the critical period in fever therapy. It is during this time that careful observation must be made on patients, such as: Rate and character of pulse; temperature; color and blood pressure. The rate of fever induction in various patients differs greatly and, consequently, I have found that an automatic electric device for constantly indicating rectal temperature is particularly indispensable for good fever therapy. Such devices are of no value when short wave is combined in the method for induction of fever.

Humidified atmosphere surrounding fever patients results in less dehydration, no change in Blood Volume and viscosity for various reasons[8]. Cool water and saline may be ingested by patients in copious quantities without fear of loss of patient's temperature. Early in the work we used to give patients warm fluids and in very limited quantities. Sweating at a minimum takes place in the highly humidified atmosphere. This is also a great improvement over previous methods of dry hot cabinets or methods where patients were confined in bags and packs which was accompanied by a great amount of sweating and dehydration and often consequent vascular collapse.

I would like to say a word of caution here against carelessness in insulating patients in blankets after fever therapy, without frequent taking of temperature and gradual removal of blankets to assure of a steady fall in temperature. Patients with normal temperatures, if placed in packs, will build up high temperatures if insulated against heat loss; the more so, patients who are packed, in whom high temperatures already exist. I have known of at least four patients, the death of whom can be traced to such handling. These accidents, in the light of present knowledge, have no reason to occur. The use of fever apparati has been boycotted in Institutions where such deaths have occurred, when the cause of death was not due to inefficiency of apparatus, but a lack of understanding of body physiology and a consequent negligence in after care.

Changes in acid base equilibrium occur during Fever Therapy, but critical levels are not ususal with high humidities where dehydration is less. In severe dehydration and hyperventilation we find marked tendency to alkalosis[8] during fever therapy. Administration of sodium chloride during treatment of patients lessens the tendency to diminution in chloride concentration in the blood.

With the cabinet run at lower temperature and higher humidity, the patient's skin does not get so hot. Less stimulation to sweat glands occurs and less stimulation to nerve endings. Patients exhibit far less restlessness with this cooler skin, run lower pulse rates, and we are seeing much less delirium than in the earlier days of fever therapy.

Delirium is a very indefinite factor in fever therapy. Individual cerebral reactions to heat are as varied as are the alterations in psyche on alcoholic imbibition. Many patients are delirious at low temperatures. Delirium is of no particular importance except it occurs during moments of extreme hyperpyrexia. With good technic, understanding and control of equipment, with avoidance of flights of hyperpyrexia above 107.2 — 107.4° F., delirium need cause no worry to the fever staff. However, delirium and mania, accompanied by vomiting, especially projectile, may be the first indication of cerebral edema due to hyperpyrexia. It is such possibilities that make the organization of a Fever Service, and training of fever technicians so vital to safe fever therapy.

Fever Therapy, especially in the higher brackets above 106°F., should not be undertaken by anyone inexperienced with the use of fever therapy at lower temperatures, and without a thorough acquaintance for at least one year's time with the apparatus he is using. No technician other than a trained nurse should give even lower and short fever treatments. New symptoms continue to present themselves on any fever service. Often these symptoms are only recognizable by the nurse drawing from a fund of general nursing experience. Any unanticipated or new symptoms should be recognized and transmitted immediately to the physician responsible for the conduct of the treatment and this physician should never be elsewhere but within immediate call.

Fever Therapy should be confined to institutional practice except in extremely rural communities, and the responsibility for the service should be carried by one or two physicians, only. Their duty should be acceptance for fever therapy, they should write appropriate prescription for fever therapy, with consideration of the disease to be treated, and the patient's physical condition. They should give preliminary instruction and care to the patient before treatment. Such care to include physical preparation such as the intestinal canal, ordinary sedation, pre-treatment parental fluid administration if indicated, and the like. Such a doctor should be frequently present during the induction of Fever in all patients and constantly present with the nurse in all cases where abnormal difficulties either of physical or psychic nature present. After the period of induction, he should again visit the patient and decide on subsequent sedation of the patient, and suggest alterations in routine as indicated by the patient's physical reactions as the treatment progresses. Late in the treatment fatigue syndromes may develop, at which time the patient may need medical help. The doctor in Fever Therapy should carry the responsibility for ordering stimulants or infusions or lowering the temperature as the needs may present.

At the termination of the treatment, the patient must be handled very carefully. Any patient who has received five hours of fever therapy above 104°F. is probably in condition where he will go into shock very easily if he is permitted to help himself or sit upright. For this reason, patients should be lifted, without effort on their part, from the fever cabinet to stretcher and back to their own beds. The doctor in Fever Therapy should see the patient at this time and again may be called on to prescribe for the patient. He should remain within immediate call until the patient's temperature has passed below 100°F. After this time, and not till then, can he feel free to absent himself from the Institution, and even then he is still on call.

I believe it is little realized by the profession at large what the technic of careful fever therapy involves in strain upon personnel. Fever

Therapy is not a matter of just turning on the heat, it is a serious, painstaking major procedure from beginning to end. Patients are made very sick, and unlike many surgical cases, vigilance cannot be relaxed after a few hours.

In discussion of fever therapy, the question always arises as to the comparative value of Fever induced by Malaria or Foreign Protein and that induced by Physical Means.[9] I, personally, after eight years of close association with physically induced fever, with personal supervision of over 2000 treatments, and comparison of the two methods, am much in favor of Physically Induced Fever. The reasons are graphically recorded in the appended table.

In speaking of the accuracy and safety of fever therapy, I would say that today we are using fever therapy in numerous conditions, and Fever Prescriptions are written with precision as to elevation and duration.[10]

1. High temperature initial treatments all given at same elevation — 106.5 — 107°F. for ten hours of continuous Fever — are used in all Neisserian cases where the risk permits. A good end result can be predicted in probably all cases in one or two treatments if the treatment can be successfully carried out. The rationale is that of submitting the invading organism to a lethal temperature tolerable to the human organism.

2. Temperatures at slightly lower levels — 105 — 106°F. — in cases of gonorrhea who are poorer risks and in whom the treatment is combined with sulfanilimide or sulfapyridine.[11] Here, again, good results ensue but more treatments are needed, perhaps four, at three day intervals.

ADVANTAGES OF PHYSICALLY INDUCED FEVER

As Compared With Fever Induced By Malaria Plasmodium, Vaccines and Foreign Proteins

Physically Induced Fever	*Malarial Fever*	*Vaccines and Foreign Proteins*
1 Temperature regulatory mechanism not disturbed.	Malfunctioning of patients' mechanism for heat loss.	As in malaria.
2 Temperature at all times under control.	Temperature not under control.	Temperature not under control.
3 No chills.	Chills	Chills?
4 Treatment promptly interruptible.	Quinine of no use for acute hyperpyrexia	More easily controlled than malaria, but not as easily as PHYSICALLY. INDUCED FEVER.
5 Rise in temperature due to no disease and no reaction to toxins.	Introduction of a disease into the organism	Introduction of substances acting toxicly on the organism.
6 May be conbined with any form of chemotherapy	In syphilis, the conjoint use of arsenicals may kill malarial parasites.	Concommitant treatment with arsenicals possible.
7 Patients watched at all times throughout febrile period.	Patients usually less adequately nursed.	Patients not continually watched as in malaria.
8 Multiplicity of uses, with possibility of control.	Used principally in syphilis.	Used in numerous conditions.
9 Controllability permits acceptance of physical risks.	Risks more hazardous than in P. I. F.	?
10 Economical in patient's time.	Economical loss greater.	?

ADVANTAGES OF FEVER INDUCED BY MALARIA PLASMODIUM, VACCINES AND FOREIGN PROTEINS AS COMPARED WITH PHYSICALLY INDUCED FEVER

Malarial Fever	*Physically Induced Fever*
1 Heat-sensitive individuals can be treated.	Treatment contraindicated in heat-sensitive individuals.
2 Demented and uncooperative patients can be treated.	Demented and uncooperative patients offer great difficulties.
3 Less expensive to patient per treatment course.	More expensive to patient per treatment course.
4 Each course of treatment requires less time than in artificially induced fever.	Each course of treatment requires more time.
5 Number of patients not limited.	Available to limited number of patients.

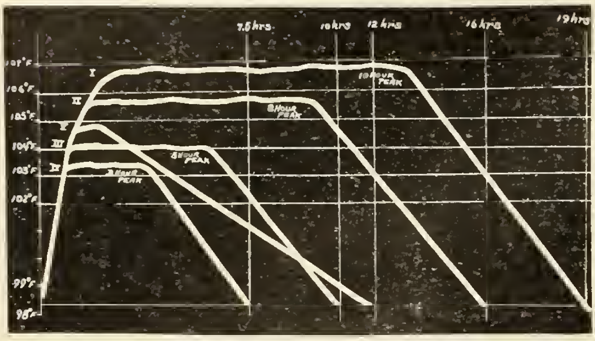


Fig. II.—Schematic representation showing the total duration of various fever prescriptions: I. Sustained ten-hour peak temperature above 106.5°F. Approximate total febrile period, including induction and recession, about nineteen hours. II. Slightly lower sustained temperature of shorter duration. III. Temperatures not exceeding 104°F. and a five hour peak. Total febrile period, ten hours. IV. Short low fever treatment with sustained peak. Total febrile period, seven and one-half hours. V. Elevation to peak temperature with slow gradual fall. Total febrile period twelve hours.

This diagram graphically depicts the relative difference in the selection of risks for controlled fever in prescriptions I and II, as compared with prescriptions III, IV and V.

These same temperature levels—105—106°F. — for five hours constitute the treatment for syphilis in patients who are unusually good risks. Unusually good risks in tertiary lues, however, are not frequently found. These temperatures are given in a series of ten or more, and usually combined with some chemotherapy.

The same fever levels are used in cases of Sydenham's Chorea which responds very well to treatment. Perhaps 65% of complete remissions in six treatments with total hospital stay during fever therapy of three weeks.

3. Slightly lower temperatures at 104—105° F. for five hours are used in general run of Luetic cases, especially in CNS Lues. Also given in series. Any temperatures above 103°F. for 60—90 hours total, usually will show a response in serology or symptoms in 80% of the cases treated.

4. Short treatments—102—103°F. — are used in low-grade infections and in cases requiring metabolic stimulation.

5. Sudden peak temperatures of 104°F. with slow fall are used with good results in atrophic arthritis.

The literature abounds with recommendations for fever therapy,[12] but the field of definite usefulness is narrowed down to less than twenty diseases at present. It is well to suggest that fever therapy may be used in this, that, or the other disease, but the indications are very definite and could be stated as follows:[13]

1. Fever Therapy must offer a prognosis not possible without its use.
2. Fever Therapy must allow a shortening of duration of an illness with avoidance of complications otherwise impending or probable.
3. Fever Therapy must never be used in any case where other satisfactory and less hazardous methods are available.

With these rules in mind, the following diseases present definite indications for Fever Therapy:

Syphilis in all stages[5] — especially valuable in CNS Lues[14] and Resistant Non-symptomatic Cases. Usually combined with chemotherapy.

Gonorrhea — all cases except anterior Urethritis in the male. Fever may be combined with sulfanilimide.

Arthritis — gonorrheal and atrophic.

Chorea — Sydenham.

Peripheral Multiple Neuritis, including those of virus origin.

Neuritis and Myositis — only after other local measures have proved unsatisfactory.

Brucellosis (Undulant Fever).[15]

In Meningococcus Septicaemia, patients should be given treatment in selected cases due to susceptability of the organism to heat.

Phlebitis — Low, short fevers, especially in Phlebitis Migrans, have proven satisfactory in a short series of cases.

Metabolic stimulation — Maximum circulatory effects are evidenced at 104°F. with increased blood flow and leucocytosis.

180 Fort Washington Avenue

REFERENCES

1. Putnam, T.J.: Diseases of the Nervous System, Jr. A.M.A., 112:18, 1779, (May 6) 1939.

2. Wagner-Jauregg, Julius: Die Tuberkulin—Quecksilberbehandlung der Progressen Paralyse, Therap. Montsh 28:1, 1914.

3. Wagner-Jauregg, Julius: Uber Die Ein Wirkung der Malaria Aufdie Progressive Paralyse, Psychiat. — Neurol. Wchuschr., 20:132, 251, 1918-1919.

4. Hinsie, Leland B. and Carpenter, Charles M.: Radiothermic Treatment of General Paralysis, Psychiatric Quarterly, (Apr.) 1931.

5. Simpson, Walter M. and Kendell, H. Worley:

(*Continued on Page 93*)

NEW PROVISIONS OF FEDERAL OLD-AGE AND SURVIVORS INSURANCE EFFECTIVE JANUARY 1, 1940

The new provisions of Federal Old-Age and Survivors Insurance, effective January 1, 1940, may have an abiding interest for doctors as a means of eliminating, or at least reducing substantially, the economic misfortunes occasioned, in many cases, by death. A brief summary of those provisions which might be of special interest to the general family practitioner follows.

New survivors benefits are payable on the death of an insured wage earner after December 31, 1939. In contrast with the old-age payments after age 65, survivors benefits are payable without regard to the age of the deceased. In all cases, the person on whose wages the benefits are based must have been a wage earner in business or industry, after 1936, and must meet the eligibility requirements. Detailed information of these requirements may be obtained from any of the forty-four field offices of the Social Security Board, located in the principal cities of New England.

Kinds of Survivors Benefits —

1. Monthly cash benefits for insured wage earner's widow, after age 65, until she remarries or dies.
2. Monthly cash benefit for insured wage earner's widow, regardless of her age, while she has in her care deceased's unmarried dependent children under age sixteen, or under age eighteen if still attending school.
3. Monthly cash benefit for insured wage earner's unmarried dependent child or children under age sixteen, or under eighteen if still attending school.
4. Monthly cash benefit for insured wage earner's dependent parents, after age 65, if no widow, or child under eighteen, survives.
5. Lump sum if insured wage earner leaves no survivors immediately entitled to monthly benefits.

Examples of Survivors Benefits —

	With 3 years of Coverage		
Average monthly wage of deceased worker	One Child or Parent 65 or over	Widow 65 or over	Widow and 1 Child
$ 50	$10.30	$15.45	$25.75
100	12.87	19.31	32.18
150	15.45	23.17	38.62
250	20.60	30.90	51.50
	With 5 years of Coverage		
$ 50	$10.50	$15.75	$26.25
100	13.12	19.69	32.81
150	15.75	23.62	39.37
250	21.00	31.50	52.50
	With 10 years of Coverage		
$ 50	$11.00	$16.50	$27.50
100	13.75	20.62	34.37
150	16.50	24.75	41.25
250	22.00	33.00	55.00

Complete information on this subject may be obtained by directing the inquiry to "Social Security Board Field Office," at the nearest of the following locations:

Connecticut—Bridgeport, Hartford, New Britain, New Haven, New London, Stamford, Waterbury and Willimantic.

* * *

INDUCED FEVER

(*Continued from Page 92*)

Experimental Treatment of Early Syphilis With Artificial Fever Combined With Chemotherapy, Fever Therapy, Paul B. Hoeber, Inc. (Pub.) 1937, pg. 143.

6. Transactions of the First International Conference on Fever Therapy, New York City, (Mar,) 1937.

7. Winslow, C. E. A., Herrington, L.P. and Gagge, A.P.: Physiological Reactions of the Human Body to Various Atmospheric Humidities, Am. Jr. Physiology, 120:2, 288, (Oct.) 1937.

8. Pijoan, Michael: Discussion — (Snow, William B.) The Rationality, Practicability and Limitations of Induced Fever As A Therapeutic Agent, Med. Rec. (Dec. 21) 1938.

9. Giles, Upton: Present Status and Technic of Artificial Fever, Arch. of Phy. Ther., X-Ray, Radium, 17:263-276, (May) 1936.

10. Snow, William B.: The Rationality, Practicability and Limitations of Induced Fever As A Therapeutic Agent, Med. Rec. (Dec. 21) 1938.

11. Ballenger E.G., Elder, O.F. and McDonald, H.P.: Sulfanilamide and Thermotherapy in Gonococci Infections, J.A.M.A., 109:13, 1037, 1937.

12. Krusen, Frank H. and Elkins, E.C.: Fever Therapy by Physical Means, Counc. on Phy. Therapy. J.A.M.A., 112:17, 1693, 1939.

13. Snow, William B.: Further Advances in Fever Therapy, Med. Rec. 147:7, 306 (Apr.) 1938.

14. Bromberg, L.: Artificial Fever Therapy — Report on Three Years Clinical Experience, Missouri St. Med. Assn. Jr., pg. 24 (Jan.) 1939.

15. Prickman, L.E. and Popp, W.C.: Treatment of Brucellosis by Hyperpyrexia Induced by the Simpson-Kettering Hypertherm, Proc. Staff Meeting, Mayo Clinic, 11:506-510, Aug. 5) .936.

Industrial Medicine of Tomorrow

CLIFFORD KUH, M.D., DR. P.H.,
New Haven, Conn.*

The outer face as well as the inner consciousness of American industry are changing significantly. One sees today modern, air-conditioned buildings where men work in a wholly protected environment, research laboratories sponsored by industry springing up on all sides to study basic problems and to broaden markets, financing and management becoming more highly developed. It would seem only natural that there would be new opportunities for, and demands upon, the physician who serves workers in this industrial world of tomorrow.

Viewed in the light of the rapid changes in industry whose ultimate ramifications stir the imagination and reach out to goals far beyond what most of us in this day and age can visualize, compensation laws, which less than thirty years ago began to place responsibility upon the American employer for the well-being of workers, were after all but an incident in a chain of circumstances which are setting the physician in a different and more important relationship to industrial management.

Just within the past year the function and scope of one phase of medical service in industry, the pre-employment examination, has been more clearly defined by the Industrial Commission of Wisconsin in cooperation with a medical subcommittee of physicians and with representatives of both labor and management. In addition to the physical examination it is advocated that there be included "a chest x-ray (flat plate); blood serology for the diagnosis of syphilis; urinalysis for sugar and albumin determinations only, and blood examination to include Tallqvist hemoglobin determination and a cover glass blood smear for a quick indication of red and white corpuscle content."

The unique recommendation is also made that a summarized report of the important findings of the pre-employment examination be given to both employer and employee. Whether the latter is accepted for a job or not, he should know the status of his health. Causes of rejection are fairly definitely specified. When indicated, a copy of the examination record is sent to the family doctor. Complete periodic re-examination at two-year intervals is recommended for all employees, partial physical re-examination or specific laboratory tests to be repeated more frequently at the discretion of the examining physician, depending on the hazard to which the employee may be exposed.

It is interesting and important to note that the impetus for Wisconsin's physical examination program came from without the medical profession.

More recently we read of the Rochester (N.Y.) Plan, approved by thirty-six industries in that city, to protect the older worker by providing that the ratio of employees over forty years of age to younger employees be permanently maintained as far as possible at present levels. Again the impetus to preserve through the benefits of employment the economic status and consequent physical and mental health of the middle-aged and older worker came from without the medical profession. What an opportunity here for the development and application of newer knowledge in the practice of geriatics!

In our own State of Connecticut where upward of half-millon workers are gainfully employed, a group of industrialists, representatives of labor, university men and physicians gather periodically to discuss informally problems relating to the mental hygiene of workers in industry. Who can imagine the existence of this specific interest in a relatively abstruse aspect of industrial management fifty or even twenty-five years ago? Here again the guiding impetus came from without the pale of clinical medicine.

But organized medicine is well cognizant of important changes in industry. Through the Council on Industrial Health of the American Medical Association and through about thirty committees on industrial health in their respective state medical associations there is much afoot. Postgraduate instruction in industrial medicine and surgery and in industrial hygiene, greater opportunity among the doctors themselves for informal meeting and discussion of mutual problems and interests, are merely part of a comprehensive educational program, which it is hoped will be of material benefit to medical men in Connecticut and those other states throughout the country where, as in Connecticut, the state society is cooperating in the national program.

---

*Chairman of the Committee on Industrial Health, Connecticut State Medical Society.

From the standpoint of the employee in industry this much may be said. The thoughtful citizen must realize that, while the premium put upon health may bar the unfit seeking employment for the first time, the new regime will ultimately make for the better health of all concerned.

The keystone of the arch, however, is the preemployment examination, which should be thorough enough not only to establish the status of the individual as a working unit in the organization, but should serve to educate the prospective employee concerning his physical defects and errors of hygiene.

It is not implied that industry should adopt a highly paternalistic attitude toward the worker. There are practical aspects to the subject. In certain instances, particularly where the company pays the worker on a full-time basis while away from work on account of illness, a wise and economical procedure is to screen out those individuals who are not most frequently absent, presumably on account of illness, and concentrate investigative and educational effort upon them. The health program which the qualified industrial physician might recommend for a company employing a thousand workers should be very different from that for one employing fifty, just as no two cases of pneumonia should unthinkingly receive the same therapy.

The well-rounded program will be concerned with far more than the treatment of the worker who becomes sick or injured in line of duty and with far more than the prevention of occupational accidents and of occupational disease, however important these may be, because days lost from work on account of purely occupational causes are outnumbered by those due to other than occupational causes fifteen to one. Consequently, the importance of the family doctor goes without saying and his role is fully appreciated in the Wisconsin physical examination program, already referred to.

In the industrial world of tomorrow industrial medicine will, indeed, be a specialty requiring expert knowledge in an expert field. The approved specialist of the future may confidently expect certification by a yet to be organized American Board of Industrial Medicine. Far from hiding the fact that he does industrial work, of which many surgeons today are none too proud, the industrial specialist will demand adequate recognition. Nevertheless the industrial surgeon of today, who feels a certain stigma to the connotation, is not unlike the opthalmologist of a short time ago. "I can remember," said Weir Mitchell, "when older physicians refused to recognize socially a man who devoted himself to the eye alone." For the industrial as well as the ocular specialist times have changed and are changing.

It is reassuring to relate that both representatives of labor and of management have been aware that the preventive opportunities in the field of industrial medicine are as challenging as the opportunities in factory construction, in industrial research, in marketing and in financing. And now the physician himself is girding his loins for the problems ahead.

⁂

Non-residents constitute a significant part of the total number of persons dying in Hartford. The non-resident deaths in Hartford hospitals comprised 42.2 per cent of the total hospital deaths in 1936, and have averaged 36.7 per cent for the past ten years. In all other cities of similar size the average of the non-resident deaths in hospitals and institutions compared to total deaths was 20.4 per cent. These figures reveal that Hartford cares for about twice as many non-residents in its medical institutions as other cities of its size throughout the country. This high percentage of non-residents being treated in Hartford hospitals and institutions indicates the superior medical facilities, capacity, and equipment which Hartford affords its residents and the people of surrounding communities.

Hart. Bd. of Health Bull., July 1939.

Occupational Dermatoses from the Viewpoint of the General Practitioner*

JOHN G. DOWNING, M.D.,
Boston, Mass.

Occupational dermatosis may be defined as any injury, damage, or harm of the skin which arises out of and in the course of employment[1]. This includes pathologic cutaneous changes, ranging from an erythema to a carcinoma. Occupation includes any gainful employment including industry, which is restricted to employment in manufacturing and productive arts. Occupational dermatitis, or ergodermatitis (pyov work; s´pma, skin) is classified under the generic term of dermatitis venenata, an inflammatory disease of the skin caused by an external irritant, characterized by erythema, edema, and vesicles. It arises out of the employment when there is a causal connection between the conditions under which the work is required to be performed, and the resulting injury. It is received in the course of employment when it comes while the workman is doing the duty which he is employed to perform[2]. Ergodermatitis occurs when the resistance of the skin is overcome by an intense primary irritant or when the patient develops a sensitivity to a substance by prolonged contact. This substance may act directly on the skin surface, or indirectly by absorption.

Classification

Because of the multiplicity and diversity of the cutaneous contacts, some type of classification is necessary. The chief bases of division are (1) the type of agent, chemical or fungal; (2) the industries using these agents; (3) the type of pathological lesion produced; (4) the physiological cause of the dermatosis[3].

No classification will be entirely satisfactory. Industries change their processes so frequently, and use so many combinations in these processes that the method of division by industries is of little value, except in those where dermatoses appear fairly constantly. The third method also has its shortcomings, since nealry all irritants produce varying degrees of pathological change, depending upon the strength in which they are applied, and the time period over which they act. The most scientific classification is that based on the etiology, the type of agent. Irritants may be grouped as follows:

(1) Mechanical or Physical agents. The dermatoses caused by this group are the results of heat[4] or cold, radiation (radium, x-ray,)[5] electricity, mechanical irritation (pressure or friction cuts or pricks), and mechanical interference with bodily function.

The cause and pathological sequences of the injuries produced by these agents are easily recognized. Mechanical abrasions due to repeated trauma, harsh detergents, cutting oils, and contact with abrasives and sand, are frequent. Other lesions may vary from pigmentation to epithelioma[6]. The common eruption from mechanical interference with bodily function is a folliculitis occurring on the skin of employees contacting oils and silicates[7].

(2) Flowering plants and their products. White, in his classic monograph Dermatitis Venenata, gives a fairly complete list of these irritants, most of them being contacted in some occupation.

(a) Redwood, teak, cocobolo, mahogany, boxwood, satinwood, Brazilian walnut, chestnut, and oak are the common woods productive of dermatitis[8].

(b) Extracts and resins include oil of cardiol from cashew nuts, resins, and lacquers.

(c) Herbaceous plants (leaves, flowers, fruits, or roots) may need considerable patch testing to discover the offending agent. Asparagus, barley malt, celery, chamomile, flax, grain dusts, hops, pyrethrum, rice, tobacco, tulips, lettuce, figs, oranges, and lemons have been proven to be offending agents. It is interesting to note that it is the outer surface of lemons and oranges that causes the dermatitis.[9]

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

(3) Vital agents. They belong to the vegetable and animal kingdom. The vegetable kingdom, due to its bacteria, yeast, yeast-like organisms, and molds, produce some very serious industrial diseases. Folliculitis, furunculosis, streptococcus infections,[10] anthrax, erysipeloid, sporotrichosis, and coccidoidal granuloma are disabling and even fatal illnesses.

The animal group, such as mites, or spiders, produce annoying but trivial eruptions. Once the cause is determined, they respond readily to applications containing sulphur.

(4) Chemical agents. They are so complex that they defy any exact classification. They may be divided into: inorganic compounds, acids, bases and salts, hydrocarbons and crude coal tar products, oils, tars and turpentine, and other organic compounds such as dyes. A list of this group is impossible, for every chemical will eventually irritate and produce a dermatitis in some one individual who has an idiosyncrasy to it. One must be careful not to condemn an occupation because of a hypersensitive worker, for it is easier to change his work than to condemn the process, thereby, depriving other workers of their livelihood unnecessarily. We soon learn to recognize the true hazards, such as arsenic, chrome compounds, chlorinated naphthalenes, rubber accelerators, pitch turpentine, creosote, and bakelite resins[11].

Massachusetts, being a manufacturing centre, shows a fairly diversified grouping of cases of cutaneous eruptions occurring in industry. In reviewing a group of 1004 private patients who suffered from occupational dermatoses, it was found that the major incidence was in the boot and shoe industry. This is not surprising, for this industry is one of our largest; nor is it unexpected, when one considers the large number of possible hazards in this work.

Benzol used in rubber cements and cleaners is the most important one[12]. Naphtha removes the protective oil from the skin; this is equally true of ether, acetone, and ethyl and methyl acetate. Methanol (used in wood heel coverings) which has an affinity for ectodermal tissue will produce eruptions in susceptible persons.

The eruptions produced by these chemicals are due to sensitizations which occur from prolonged contact, or after a resumption of the work following an interval of vacation. In this group there were 219 cases, of which 106 were the men who clean, dress, and iron shoes — the so-called treers[13]. Tanners, cementers, and dressers of shoes were next in incidence, with 89 cases. The remainder showed industrial idiosyncracies to leather, or to a single chemical.

One never considers that the housewife may be the subject of an occupational eruption until we consider that the second largest group of patients were employees in the hotels and restaurants, doing similar work. They are exposed to alkalies and water, their hands being constantly wet. They also develop sensitivities to fruit and vegetables. This group composed 134 workers. In the review of these 1004 cases the importance of soap and water as a causal factor was amply demonstrated[14]. In at least 249 cases, or nearly 25 per cent, soap and water constituted at least a contributing factor in the production of an eruption. The methods of cleansing the skin for the removing of the grime at the end of the day's toil may cause a dermatitis. There are many occupations in which soap and water play an unsuspected part, such as among painters, rubber spreaders, and building porters. Forty-nine printers suffered eruptions from contact with chromates, kerosene, and various acids. Forty-four workers with petroleum, gasoline, and lubricating oil suffered from lesions varying from a dry, fissured skin, to extensive eruptions which are extremely resistent to treatment. Clothing saturated with gasoline should be immediately removed from contact with the worker's skin.

The remaining cases were divided among various occupations, such as among woolen workers, building cleaners, rubber workers, garage workers, painters, builders, outdoor workers in public utility service, bakers, and workers in miscellaneous occupations. The miscellaneous group included sporadic cases who demonstrated individual idiosyncrasies. Women who make ornaments for lamp shades show interesting examples of sensitization remaining after cessation of contact with the irritant. They spread mica which has been dipped into shellac onto frames. As long as they continue to work, they may not suffer a dermatitis; however, if they stop for any length of time and then return to that occupation, they suffer an outbreak in a comparatively short time.

When a worker presents a dermatitis, it is important both from an economic and from a public health point of view to decide immediately, not only whether it is occupational or non-occupational, but also to decide whether or not it is contagious or infectious. If it is in the latter, this worker may infect other workers; if the former, the work may affect others. A knowledge of dermatology will decide the differentiation of the cutaneous disease present, while a knowledge of the work may solve the industrial question.

However, physicians cannot be expected to know all industrial processes in their community. Information may be obtained from the plant foreman or sanitary engineer. Insurers have trained investigators; the Massachusetts Industrial Accident Board sends out inspectors on request. Information can generally be obtained if desired. A careful history from the patient is essential. He should be questioned repeatedly about the details of his work, from the time he enters the shop until the time he leaves. His pastimes and contacts at home may disclose a causative or contributing factor. Careful history taking will narrow down the number of possible irritants, and the patient should be patch tested with these substances, bearing in mind, however, the limitations of this test, knowing that it is impossible to reproduce the worker's environment or contacts, such as repeated friction, minute cuts and abrasions, heat, moisture, fumes, and the constantly changing combinations which are present in many industries.

The Patch Test

The patch test is a simple procedure. The suspected irritant, covered with a piece of moistened linen and a still larger section of cellophane, is fastened to the skin by means of adhesive plaster. A piece of linen soaked in a solution of the irritant is similarly applied. The cellophane keeps in the mositure, and being larger than the linen, helps to differentiate the central reaction of the test substance, and that which may arise from the adhesive plaster[15]. If the patient is highly sensitive to adhesive, or a solid substance is to be tested, the test object or substance should be covered with a moisture-proof material, and held to the skin with cotton bandages. The substance should be left on the skin for twenty-four hours or longer, unless there are subjective symptoms. A volatile substance may be tested by having the patient rest his forearm on the open mouth of a bottle containing the solution i.e. turpentine or gasoline. When using extracts of plants, essential oils, and volatile solvents, the greatest care should be exercised; they should not be covered. They should be applied either by dropping them on the skin,[16] or by wetting the stoppers of the vials containing the substances,[17] and lightly touching the skin. Lacquers and paints may be painted on the skin. Powders should be applied in dry and moistened states[18]. Appropriate solvents such as weak acids or alkalies, if properly controlled, may be employed and similarly those soluble in fat may be tested in oils or vaseline. Patch tests should be applied and removed by the physician. In compensation and medico-legal cases, he cannot testify to the results of contact tests unless he has administered them. A reaction to be positive must have caused lesions similar to those of the eruption in question. If it is an erythemato-vesicular one, the test, should show erythema and vesicles; if acneform, such as occurs after exposure to chlorinated naphthalenes, the test should show similar follicular plugging and papules.

After the tests have been applied, the patient should remain at least one hour at the physician's office; then the patient should be questioned as to subjective symptoms of burning, itching, or tenderness, and the sites should be examined if one is dealing with new chemicals whose composition is unknown to the examiner. One may be dealing with a primary irritant, which should not be used in a patch test, for it might cause necrosis in a very short time. Too many closely allied chemicals should not be used at the same time. The interpretation of the results of patch testing requires experience, knowledge, and judgment. They should not be applied hap-hazardly. The author has seen a case of simple dermatitis venenata of the hand transformed into a dermatitis exfoliativa by the use of a patch test, and a case of a man who had recovered after suffering three months from a disabling, generalized dermatitis be promptly re-hospitalized with a severe recurrence due to amateur patch testing, done by an intern. False negatives are deceiving. It is impossible to test adequately for air-borne poisons, physical agents and their influence, powders and oils, which interfere with bodily functions or vital agencies, or to reproduce the ever-changing chemical combinations of an industrial process, or the prolonged contact day after day with weak solutions or steam. A negative result may occur from a test with too weak a concentration. The area tested may not have been properly selected. The anterior aspect of the forearm is a favorite test site for many dermatologists. The patient may be in a state of hyposensitivity and the tests should be repeated at a later date.

False positive reactions may be due to the employment of substances which injure normal skins. Normal persons should be used as controls when testing with chemicals of unknown composition. One should be sure that the patient is tested with only the chemicals to which he is exposed; for instance, the employee may believe he has been affected by chrome when there was no chrome used in the industrial process at which he worked. It must be remembered that the application of a chemical under an occlusive dressing for twenty-four to seventy-two hours is more exacting than an ordinary industrial exposure. Patch tests are of great value in the investigation of occupational dermatoses, but they must be wisely interpreted and properly employed.

Treatment

The treatment should be both prophylactic and curative. Hazards should be eliminated. The worker's environment should be kept absolutely clean. Mechanical devices should replace manual contact, and where this is impossible, gloves should be worn, or protective creams or liquids may be tried. Careful supervision and instruction may prevent many disabling dermatitides.

When a worker presents an occupational dermatitis, the sooner he is removed from his work, the quicker will be his recovery[19]. If his eruption is severe locally, with intense edema and vesiculation, or extensive in its distribution, hospitalization is advisable, especially if both hands are affected. Warm wet dressings are of value. The alteration of two per cent boric acid solution with a solution of potassium permanganate, 1-5000, constantly for twenty-four to forty-eight hours has been found of value. If there is considerable pruritus, aluminum acetate, 5 grams in 100 cc of water, will give prompt relief in many cases. With the subsidence of the edema and a resulting oozing and desquamation of the skin, lotions and pastes will be next in order. The author has found glycerin in the various lotions to be irritating. At first the following lotion may be applied:

Zinc Oxide	30
Phenol	4
Lime Water	qs 500

If the itching is severe, zinc sulphate may be added:

Zinc Oxide	30
Phenol	2
Zinc Sulphate	8
Lime Water	500

These lotions should be applied frequently during the day. At night the following paste may be applied:

Zinc Oxide	15
Starch	15
Vaseline	30

This makes rather a stiff paste and should be applied on linen compresses; later it may be replaced by:

Zinc Oxide	4
Starch	
Vaseline	each 30

If there is any suggestion of infection, 5 to 10 per cent of sulpho-ichthyolate of ammonia (ichthyol) may be added. Soap and water should be avoided. The skin should be cleansed with mineral or olive oil and should be sponged off with either a 2 per cent hot boric acid solution, or a solution made of:

Potassium Chlorate	30
Sodium Borat	30
Sodium Bicarb	60

The above powder should be used in the quantity of a tablespoon to a quart of hot water.

Persistent pruritic patches may be treated later with ointments such as:

Oil of Cade	2
Zinc Oxide Ointment	30
Oil of Cade	8
Ichthyol	4
Magnesium Carbonate	8
Zinc Oxide Ointment	qs 60

Vesicular and infiltrated areas respond well at times to:

Crude Coal Tar	4
Zinc Oxide	4
Starch	30
Vaseline	30

However, the prolonged use of ointments seems to irritate these dermatitides, especially if they have become secondarily infected by fungal flora, such as bacteria yeast and molds.

Treatment with dyes may then be beneficial. Gentian Violet and Brilliant Green may be used in varying strengths and combinations such as:

Brilliant Green	1.2
Gentian Violet	1.2
Alcohol	60
Water	60

Various industries have sought in vain specific remedies for prompt relief of their employees' cutaneous eruptions. It must be remembered, however, that once the skin is injured, the first principle of treatment is rest, sufficient for the normal process of healing to take place in the part affected. The physician must use only soothing remedies. Idiosyncrasies to drugs such as mercury, resorcin, and picric acid, should be anticipated and guarded against by pre-therapeutic patch testing. The average period of healing is about six weeks. Ultraviolet radiation is of value if it is not used too soon; the same holds true of x-ray. Co-operation of the patient is essential and the physician soon realizes whether or not he is dealing with a malingerer. If he is, hospitalization with a fixed dressing is the only solution. It is remarkable how nature will heal a dermatitis factitia, enclosed in a plaster of paris cast, which one would expect to be irritating.

Prevention should be the motto of the physician interested in industrial medicine. This can be accomplished more readily in industrial dermatology, because the hazards can be more easily detected and eliminated than in any other branch of preventive medicine.

REFERENCES

1. Downing, J.G.: The Legal Aspects of Industrial Dermatoses. New Eng. Journ. of Medicine. Vol. 215 No. 13, pp. 577-580, Sept. 24, 1936.

2. Downing, J.G.: Analysis of Claims in Industrial Dermatoses. J.A.M.A. Vol. III, pp. 1536-1542 Oct. 22, 1938.

3. Downing, J.G.: Industrial Dermatoses and Their Treatment. New Eng. Journ. of Medicine. Vol. 206, No. 13, pp. 666-680, Mar. 31, 1932.

4. Weill, M.G.: Hyperpigmentation from Heat. Bull. Soc. franc. de dermat. et syph. 33:442, June 1926.

5. Dubreuilh, W. and Chauuse, D.: Radiodermic ulcer. Ann. de dermat. et syph. 6:161, 1925.

6. Robertson, J.: An Inquiry in Regard to the Cause of Spinner's Scrotal Cancer. J. Indust. Hyg. 6: 217, 1927.

7. Dept. of Scientific and Ind. Res. Memorandum on cutting lubricants and on skin diseases produced by lubricants. Bull. No. 2, London, 1918. p. 8.

8. Senear, F. E.: Dermatitis due to Woods. Journ. of Amer. Med. Assoc. Vol. 101, pp. 1527-1532.

9. Horner, S.G.: Dermatitis from oranges and lemons. Lancet, 1931, 2, 961.

10. Hall, A.C.: National Safety News, 1923, 8, 33.

11. Downing, J.G.: Industrial Dermatosis: Treatment and Legal Aspects: Review of Recent Literature. Journ. of Indus. Hyg. Vol. 17, No. 4, July 1935.

12. Report of the Division of Occupational Hygiene, for the year ending November 30, 1936. Reprint from the Annual Report of the Department of Labor and Industries, Page 14.

13. Downing, J.G.: The Skin and the Compensation Law in the United States (Treer's Dermatatis), in Deliberationes Congressus dermatologorum internationalis, Leipzig, Johann Ambrosius Barth, 1936, vol. 2, pp. 210-216.

14. Downing, J.G.: Cutaneous Eruptions Among Industrial Workers, a review of two thousand claims for compensation. Arch. Dermat. & Syph. Vol. 39, pp. 12-32 Jan. 1939.

15. Downing, J.G.: Are Patch Tests of Real Value in Dermatology. New Eng. Journ. of Medicine, Vol. 219, No. 18, pp. 698-703, Nov. 3, 1938.

16. Downing, J.G.: Dermatitis from Orthodichlorobenzene. J.A.M.A. Vol. 112, No. 15, pp. 1457, April 15, 1939.

17. Shelmire, A., and Black, J.H.: A Method of Patch Testing with Plant Oil. J.A.M.A. 108:719, 1937.

18. Downing, J.G.: The Diagnosis of Industrial and Non-Industrial Skin Diseases. New Eng. Journ. of Medicine, Vol. 213, No. 8, pp. 358-363, Aug. 22, 1935.

19. Downing, J.G.: The Skin and Industry. Industrial Medicine. October 1932.

* * *

When broncho pneumonia is the sole cause of death, doctors signing death certificates are requested to specify that the broncho pneumonia is *primary*. There will be no query from the State Department of Health concerning certificates which are so signed. Broncho pneumonia unqualified, however, will not be accepted by the Federal Bureau of Census or the State Department of Health without further investigation.

Hart. Bd. Health Bull., July 1939.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief,*	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Hartford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Maurice Moore, Norwich
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.— Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS — Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct: drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.— Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.— All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.— Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.— Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

THE PROBLEM OF LUNG ABSCESS

Non-tuberculous pulmonary suppuration with abscess formation is frequently a difficult problem in diagnosis and therapy. In about one-third of the cases there is an antecedent history of tooth extraction, tonsillectomy or other operation under either local or general anesthesia. Other patients have no history of operation but show demonstrable oral sepsis, poor dental hygiene with dental and gingival pathology. In a very considerable remaining group no antecedent operation or local sepsis is apparent, and the history may be only one of an atypical pneumonic onset. Clinical and experimental data suggest that direct aspiration of infected debris from the mouth and nasopharynx into the bronchial tree begins the disease; less commonly, the infarction of a portion of the lung by an infected thrombus from some peripheral septic focus is responsible, in which case the lesions may be multiple at the onset. It should be emphasized that unconsciousness associated with anaesthesia for surgical purposes is not peculiar in respect to the pathogenesis of abscess, since periods of unconsciousness following alcoholic excess, diabetic coma, cerebral apoplexy and epilepsy may occasionally be followed by the same type of pulmonary lesions.

The sputum in cases of lung abscess is characteristically abundant, purulent and foul in odor, but any of these characteristics may be absent. Complete bronchial occlusion may suppress sputum entirely; if bronchial drainage is free and few anaerobic organisms are present, the sputum may be almost odorless. Nor is the roentgenogram to be relied upon completely for the demonstration of a typical cavity and fluid level. A cavity completely filled with necrotic debris and surrounded by a zone of pneumonitis presents only a dense and sometimes homogeneous shadow.

The wellknown tendency for about fifty per cent of lung abscess cases to undergo resolution with apparent healing, either spontaneously or with such conservative measures as postural drainage and bronchoscopy, leads in many cases to unwarranted optimism and the prolongation of conservative treatment beyond a time when reasonable hope for cure ceases to exist. Just what this time is in terms of total duration of the disease is difficult to state in general terms, but if a distinctly favorable trend has not manifested itself in four or five weeks (by a decline in fever, steady decrease in amount of cough sputum, rise in red cell count, gain in weight and strength, and clearing of the roentgen signs) then a conservative cure is not to be expected. However, conservative treatment is not to be considered adequately tried unless bronchoscopy has been used as an adjunct. In addition to establishing or promoting bronchial drainage by stimulating cough and by removal of inspissated secretions and granulation tissue through suction, the bronchoscope is indispendable in discovering the occasional case due to foreign body, and particularly the cases of tumor. In adult life approximately ten per cent of pulmonary suppuration is due to malignant bronchial obstruction. The bronchoscope helps with the roentgenogram in localizing an abscess; since physical signs are notoriously meagre, and misleading at times even to a skillful internist, roentgenograms should be obtained in lateral and oblique projections as well as the usual posterior-anterior.

Artificial pneumothorax is contra-indicated in peripherally located abscess and in abscesses approximating the interlobar fissures. It is of debatable value in any case, but may be tried with caution in central abscesses when other conservative measures have failed, and for some reason the patient is considered a poor surgical risk. Phrenic nerve paralysis has not been demonstrated to be of value.

The dangers of prolonged and unsuccessful conservative treatment are the sudden spread of the infection to involve additional segments of the bronchial tree, the production of irreparable structural changes such as bronchostenosis and bronchiectasis in the involved lobe, and the formation of an empyema or spontaneous pyopneumothorax. Therefore when postural drainage, transfusions, bronchoscopy and perhaps chemotherapy have failed after a few weeks' trial, external drainage by cautery pneumonotomy is indicated. Local anesthesia is to be preferred, so that the patient may retain the cough reflex without interruption. While an occasional surgeon insists that practically all abscesses can be accurately located in relation to pleural adhesions and safely drained in a single stage operation without opening into the general pleural cavity and inducing a pyopneumothorax, it is certainly safer for the most patients to stage the procedure, concluding the first operation after resecting a short segment of two or three ribs directly over the abscess area. The formation of pleural adhesions under the operative site for a period of seven to ten days will almost eliminate the occurrence of pyopneumothorax which is a most serious complication. An added advantage of delayed two-stage drainage is the better condition of the soft tissue wounds; the danger of dissecting chest wall infections and phagedenic ulceration is minimized.

Drainage of the abscess area after the second stage (cautery pneumonotomy) is maintained by using soft rubber tubing, or gauze packs frequently used in combination. Before the drainage tract is allowed to close, roentgenograms must show clearing of the lung. The sputum should be reduced to zero or a few grams daily, and the temperature normal. Finally the sinus and bronchial fistulae should be investigated by injecting lipiodol to visualize any residual pockets or secondary bronchiectasis. This simple manoeurve, with appropriate measures taken to correct difficulties if discovered, will prevent a large number of so-called recurrences, and otherwise unexplained disappointing end-results with persistent cough and sputum.

Occasionally lung abscesses may be seen when multiple in a single lobe, or of such chronicity that organizing pneumonia, fibrosis, bronchostenosis and bronchiectasis are found. Such cases are probably best treated by primary lobectomy when the services of a dependable thoracic surgeon are available.

G. E. L.

⁂

CONNECTICUT CLINICAL CONGRESS

The striking success of the Connecticut Clinical Congress provides support and encouragement for a workable type of postgraduate medical instruction to the physician. This Congress was initiated fifteen years ago by Dr. M. C. Winternitz, of the Yale University School of Medicine. Although the original objective was the development of a postgraduate medical curriculum, there was at the time little concept of the means and mechanisms for attaining this purpose. By a process of trial and error, and with the acquisition of added experience from each succeeding Congress, the Connecticut Clinical Congress has evolved into a type of postgraduate medical institution which is being emulated by other state medical societies. Last September, the fifteenth Clinical Congress of the Connecticut Medical Society was held, and the enthusiasm manifested by participants of the sessions is definite evidence of the value of these meetings.

From the outset, the Connecticut Clinical Congress was organized on a three-day basis, and has continued with this schedule of session, but with experimentation and modification of the original pattern. The programs in the first few years consisted of demonstrations in the afternoons and formal talks in the morning. During the first eight or nine years, the attendance at the Congress gradually declined from four hundred, the registration at the early meetings, to two hundred and fifteen in 1932. In 1933 a new program committee, profiting by the experience of previous Congresses, instituted certain changes in the program. The registration fee was reduced: the afternoon demonstrations were replaced by round table panel discussions. Morning sessions consisted of formal talks by prominent individuals residing outside the State of Connecticut, while the afternoon round tables were composed of these morning speakers supplemented by members of the local community. Beginning four years ago, evening section meetings have been added to the program. This past year, five three-day courses were included in the program of the Congress, a separate registration being required for admission to these courses. The overwhelming success of the latter is seen in the fact that one-third of the registrants to the Congress also registered for the courses. An innovation in the last two years was the inclusion, in addition to the longer, formal lectures, of eighteen five-minute talks on advances in the practice and theory of medicine.

The program changes instituted during the past six years have been accompanied by a sharp increase in enrollment at the Congress. In 1936, the registration was approximately seven hundred, with a somewhat smaller attendance this year. The large enrollment can be attributed to the very broad scope of the program which appeals, in at least some of its aspects, to all doctors. The best available men have been brought to New Haven to present special aspects of medicine, with particular emphasis on newer medical knowledge. The enthusiastic response of those attending these meetings is an encouraging manifestation of the fact that the practicing physician is eager for postgraduate medical education.

In the coming September, the Program Committee will continue its experimentation with the pattern of the Congress in order to make it useful to the whole medical profession in the state. The long talks are to give way to shorter, more practical, and concise presentations. Luncheons are planned with nationally known speakers in a question and answer round table. More diagnostic and therapeutic procedures are to be presented. Dry clinics and clinical pathological conferences are also to appear on the program. The hope, of course, is that as many men as can will desire to register and participate in the sessions, whose aim continues to be to promote knowledge of progress in medical science and practice.

L. H. N.

☆☆

ECONOMIC AND SOCIAL ASPECTS OF DIABETES.

With the advent of insulin in 1922, diabetics were transferred from hopeless invalids with little life expectancy to persons with normal life conduct and an unknown but very hopeful future. For a number of years all efforts were expended in learning to use the new endocrine product. Gradually, as the length of the diabetic's life has increased, improvement has occurred in the use of insulin and in the product itself, the most recent change being protamine zinc insulin.

In 1930 to 1935 it was realized that pregnant women could have babies, but until delivery at the 36th week and control of infant hypoglycemia was learned, the babies died. Now the babies as well as the mothers have a reasonable chance of life.

In the last five years extensive statistical studies of diabetes have been made by the Metropolitan Life Insurance Company and published in their Statistical Bulletin.

In February, 1936, attention was called to the change in relationship of the mortality of diabetes as compared to that of tuberculosis. Diabetes in thirty years rose from a minor cause of death to 9th place, while tuberculosis fell from 1st rank to 7th. In certain large cities the death rate from diabetes was higher than that from tuberculosis. The opinion is expressed that diabetes is increasing through the lack of exercise and the overeating of our general population, and that more careful examinations are done revealing more cases. Also the general population lives longer, giving latent diabetes time to manifest itself. So diabetes is coming more to the attention of public health officials and demand will be made for better control and more knowledge.

Diabetic coma has become a preventable cause of death, and yet 18% of 3,519 deaths of diabetics were from coma. (Statistical Bulletin, 1936.) Also coma deaths among regular insulin users were ⅓ lower than in the entire group studied. The needful preventive measures were summarized as: (1) periodic health examinations — especially of overweight persons with a family history of diabetes; (2) distinguishing diabetic coma from coma due to other causes; (3) regular use of insulin by all who need it and (4) better use of modern method of diabetic treatment.

In discussing "Girth and Death" in the May 1937 Bulletin the following paragraph occurs: "The most striking difference of all is found for diabetes. The death rate of overweights from this disease is 2½ times that among average weights and four times that among underweights. Moreover, the margin between overweights and those of slighter build increases rapidly as the degree of overweight advances. Thus among those who are actually stout (25% or more overweight,) the diabetic death rate is more than eight times that of average weight persons, and thirteen times that of underweights."

The progress in the control of diabetes (Statistical Bulletin, April 1938) is most evident in the drastic decline since 1922 in mortality among children and young adults. Smaller but definite declines were recorded among males up to 55 years of age and among females up to 35. In the older age groups the trend is upward, and markedly so only in the oldest female group. Much of the increase is more apparent than real, due to the constantly growing number of persons at older ages, among whom the frequency of onset of diabetes is highest. Also better and more frequent urine and blood examinations are done.

Most interesting is the working capacity of diabetics discussed in the Statistical Bulletin of October, 1939. Studies of 653 diabetics from the George F. Baker Clinic between 20 and 65 years of age showed 63% of the men and 46% of the women worked without important interruptions; 27% of men and 34% of women were disabled. Considering that diabetes is classed as a disabling disease, this is a remarkable achievement by these people. In another group of 605, diabetes began when they were under 40 and they had it for 15 years. Here 90% of those still under 40 worked and lived normally. Of those over 40, 76% were normally active. In the entire group 95% reported themselves in good or fair health. Insulin was used by 92% of the younger group and 71% of the older. Another study of 100 consecutive patients in an English clinic showed serious loss of time from illness due to diabetes by only 15%. Also 39% had no loss of time because of diabetes and 38% had lost a brief period for study of their disease. Interestingly enough 45% had lost no time for illnesses not related to diabetes.

The seventeen years of the insulin era has seen a marvelous change. Diabetics live lives approaching normal in industrial activity, in family life and in duration. The best results of modern care have not yet been achieved and must be striven for through education and training. At the same time work is going forward to improve our methods and diabetics may look to the future with even more hope.

B. J. B.

* * *

CAUSE AND EFFECT

We may be pardoned if we exhibit a certain amount of pride in commenting on the paper of Doctor Daily which appears elsewhere in this issue. The medical profession, nurses, hospitals and all who have contributed to make possible the lowest recorded maternal mortality rate, may be permitted a feeling of pride. While Doctor Daily discusses primarily the death rates of mothers, it is always well to scrutinize simultaneously the death rates of infants under one month of age and of the stillbirths, for all three rates must be shown to obtain a full picture of maternal care in any community.

A study of these three rates in Connecticut gives a remarkable demonstration of progress. Maternal mortality dropped from 5.5 per 1,000 living births in 1929 to 2.9 in 1938, reaching the all-time low of 2.5 referred to in Doctor Daily's paper during the year of 1937.*

Stillbirths during this period dropped from 30.70 to 19.53 per 1,000 living births (the stillbirth rate in 1901 was 45.1 and the drop has been steady since that time).[1]

The mortality rate for infants under one month fell from 35.1 in 1929 to 26.3 in 1938. (In 1916 this rate was 44.6 per 1,000 living births and it has dropped steadily since that time).[2]

Many factors have been at work which might have influenced these rates for the good. There has been a great increase in hospital facilities, blood transfusions, etc. There has been rapid education of the public to the necessity of early and persistent prenatal care. It is to be hoped that some good was done by the postgraduate refresher courses in obstetrics. No one can estimate the extent to which birth control has played a part in this result, preventing the recurrence of pregnancies which might well have proven fatal. Some physicians feel that practical application of birth control measures in this state has been so widespread as to constitute a real contribution to lowering the death rate in childbirth.

These and many other reasons can be given but in our opinion the most powerful factor which was brought to bear at this very time is the awakening of a spirit of self-criticism on the part of the profession itself; reviewing its failures and learning from its mistakes. As a corollary, there has been a rapid extension of the willingness of the profession in its hospital staff relationships to assume a protective responsibility for private practice of inexperienced physicians. Never before has hospitalization of obstetrics been so complete and never before has it been so easy and so natural for programs of supervision and enforced consultation to develop.

There is no space available at this time to record the many obstetricians and organizations who have contributed thus to mold the obstetrical conscience of our day. It is a fact, however, that this has come about quite rapidly to lessen the dangers of the delivery room. Thoughtful physicians have long regarded this phase of the problem as of more significance than all others combined.

When the State Medical Society's Advisory Committee considered the most advantageous way to expend the funds provided by the Social Security Act, it was only natural to concentrate activities in Windham County where for many years there had obtained the highest mortality rate in childbirth. Much to our surprise, however, Windham County produced the lowest puerperal death rate in the state for the year just prior to the establishment of the program. If such a change in the rate had been shown one or two years later no one could resist the temptation to claim cause and effect.

'Post ergo propter' is dangerous reasoning. Few physicians, e.g., are aware that the diptheria rate began to decline years before antitoxin was introduced. No one will deny the good that antitoxin has done but we neglect other factors. We are in the position of a theatrical critic who has been so fascinated with the artistry of the leading actor that he forgets the excellence of the supporting cast without whose work the play would have been a failure.

In 1928 the writer, on the basis of a study of the puerperal deaths in Hartford for twenty years, ventured to say that a puerperal mortality rate of approximately 1.25 could be attained. Those of us who review case histories in this connection know full well that our present rates of approximately 3 per thousand living births are still twice as high as they should be.

---

*A difference is noted between the rate of 2.5 given by the Federal Bureau and 2.8 for the same year as reported by the Connecticut Bureau of Vital Statistics. In this instance three deaths were eliminated by the Federal Bureau which had been included in the 'puerperal' causes of death by the State Bureau.

Connecticut is not alone in showing these improvements and in the case of maternal mortality the rates have fallen so rapidly over a large section of the country that there has arisen considerable speculation as to the causes and it is quite to be expected that credit be claimed on behalf of the Social Security program and even for its precursor, the Shepard-Towner Act (no Shepard-Towner money was taken by Connecticut).

We have indicated our pride in attaining low rates, our continued dissatisfaction with these low rates, and we point to the method by which we can continue to improve which is the prompt supervision by experienced and well trained obstetricians of all abnormalities of pregnancy at the first sign of their appearance. Not only the provisions of the consultation service paid for by Security Act funds, but the generosity of the medical profession, makes it certain that no pregnant woman in Connecticut need suffer for want of skilled service.

J. R. M.

1 Connecticut Health Bulletin 52; August 8, 1938.
2 Connecticut Health Bulletin 51; September 9, 1939

⁂

UNCLE SAM COUNTS NOSES AGAIN

The 16th Decennial Census is already underway and will serve to bring up to date the statistical record of the United States. Statistics may sometimes lie but they are a necessity if we are to mark progress. The first census in 1790 was made for the determination of representation in Congress. Taken at ten year intervals since 1790 these censuses provide the most important link between the present and the historical past. They provide an actual measurement of the growth in population and in resources of the greatest nation on earth.

It is of interest to note that during the 150 years spanned by the census the center of population has moved from the Atlantic seabord to Indiana and the geographical center to Kansas. The period of greatest percentage growth was the decade between 1800 and 1810, when the increase was 36.4 per cent. This rate of increase remained fairly constant down to the decade between 1860 and 1870 when it showed the first decided drop. The rate of increase declined to 14.9 in 1910-1920 and registered again a slight increase to 16.1 in 1920-1930.

Census facts have taken on a new value since the Federal government has embarked on a program of social planning. Uncle Sam, himself, by reason of his investment in housing, farm loans and business loans has become the world's greatest banker. Census facts provide his most important operating statistics. Important movements like social security; maternal and child welfare; health; housing; unemployment relief, and the whole agricultural program, based on production levels as shown by the Census, are examples of the increasing need for guiding facts in a society of increasing complexity.

The Census records show the transformation of the American people from a 95 per cent rural ratio to a major urban status. Census records contain convincing evidence of the prolongation of human life.

The economic censuses — business, manufactures and mines and quarries — began early in January. The "domestic" enumerators are scheduled for April. It is essential that every citizen lend his full cooperation toward making this census a complete one. Perhaps more than any other group, the medical profession will benefit by this census in that it will thus be enabled to bring up to date its statistical data on the health of the nation's population. Individual census reports are not available to any government department and will not be used for taxation, regulation, or investigation.

Uncle Sam, proceed with the count!

⁂

NEW ARMY MEDICAL LIBRARY AND MUSEUM

"The acquisition of a site for a new Army Medical Library and Museum building in Washington was recommended by the President in the budget for the fiscal year of 1941, which he submitted to Congress January 4," *The Journal of the American Medical Association* for Jan. 13 states. "The budget contemplates that the Congress shall appropriate $600,000 for the purchase of the site and for preliminary expenses in connection with the building to be constructed and that the site be selected on East Capitol Street, in Washington, adjacent to the Congressional Library group. Thus moved one step further toward fruition the hopes and petitions of physicians that a structure be provided in which the vast collection of invaluable medical literature comprising the Army Medical Library, often spoken of as the Surgeon General's Library, may be safely and adequately housed. The Seventy-Fifth Congress authorized the construction of such a building to cost $3,750,000 but did not appropriate any money to make effective its authorization. The recommendation contained in the budget for 1941 is now before the Committee on Appropriations of the House of Representatives."

From the Secretary's Office

CREIGHTON BARKER, M.D.
258 Church Street New Haven

Henry L. Swain

Although Doctor Swain had lately withdrawn from active participation in the affairs of the State Society his influence will be felt for a long time. During the years of his service on the Council it is not recalled that he ever missed a meeting and he always supported every measure that would further progress and accomplishment by the Society. His ideals were the highest, he served unselfishly. The Society owes him a great debt and in his passing the Secretary feels a deep sense of personal loss.

* * * *

Delinquent Members

At the close of the year 1939 there were thirty-two members of the Society dropped for non-payment of dues as provided in the bylaws. By county these delinquent members were:

Fairfield	13
Hartford	5
Litchfield	1
Middlesex	—
New Haven	9
New London	—
Tolland	3
Windham	1

* * * *

Committee on Arrangements For Sesquicentennial

The 150th anniversary of the founding of the Society will be held in Middletown during the year 1942. Preliminary plans for this celebration are now under way. The Middlesex County Association has appointed a Committee on Arrangements consisting of Doctor Roy L. Leak, Chairman; Doctor Charles Russman, Doctor Harry Frank, Doctor Carl Chase and Doctor Harold E. Speight.

Later a committee from the Society as a whole will be designated.

Committee on Prepaid Medical Service

The Committee on Prepaid Medical Service, under the Chairmanship of Doctor Samuel C. Harvey, is progressing with its study of the costs of medical service and a review of prepaid medical service plans that have been proposed or are in operation elsewhere. Efforts are now being made to gather information concerning the public interest in such proposals. It is planned that the Committee will have a series of conferences with various representative citizen groups.

* * * *

New England Health Institute

The Society's section of the program for the New England Health Institute in Hartford, April 15-19 will be presented on Wednesday afternoon, April 17. At two o'clock Doctor Joseph Howard of Bridgeport, Chairman of the Society's Committee on Public Health, will speak on "A Study of Maternal Mortality in Connecticut." At three o'clock Doctor J. Root of Waterbury, Vice-President of the New Haven County Medical Association and member of the Society's Committee on Public Health, will speak on "The Private Practitioner and the Public Health;" and at four o'clock the Society's Executive Secretary will speak on "Organized Medicine and the Public Health." Doctor Joseph I. Linde, the President of the Society, and several other members will have parts in the general program of the Institute.

* * * *

Connecticut Branch, American Association of Medical Social Workers.

The Connecticut Branch of the American Association of Medical Social Workers will have their annual meeting in conjunction with the Annual Meeting of the Society in Hartford in May.

NEW HEALTH INSURANCE BILL
Redrafted by American Association for Social Security.

Taking the original health insurance bill drafted in 1934 by Abraham Epstein the American Association for Social Security is now formulating a redraft of the bill for presentation before the legislatures of the individual states, and for supplementary presentation in Congress. Sitting in the downtown New York office of the Association for Social Security, its executive Secretary, Mr. Epstein, informs us of difficulties encountered in attempting a redraft of the bill made necessary by the impossible proposals of the Wagner Bill and by experience in social insurance of the last few years. The redraft is being prepared by Professor Herman A. Gray, director of the Association for Social Security and chairman of the New York State Unemployment Insurance Advisory Council.

As in the Association's original model measure of 1934 the new bill proposes a compulsory health insurance system providing cash, medical and maternity benefits to ill workers and their dependents. Financing of the measure is to be by contributions on the part of employers, workers, and the government.

Three Groups Pay the Costs.

Three or four wage classes will be designated and three groups will participate in the costs by paying specific weekly sums. In the lower wage brackets the amounts contributed by employers and government will be proportionately higher than in the higher wage groups making, we are told, a "more socially progressive" program than that existing today in old age insurance.

To Cover Those Earning Less Than $2,000

The new bill is expected to cover all manual workers and non-manual workers earning up to $1,500 or $2000 a year, instead of up to $3,000 as provided in the 1934 bill. It will, however, extend the coverage to workers employed by firms of less than three employees. Those not compulsorily covered and who earn less than the wage stipulated for the compulsory coverage as well as formerly covered workers who earn slightly higher wages may join voluntarily but can receive medical benefits only.

Cash Benefits

· Using the same wage classes as for contributions, the cash benefits to be paid to workers unable to work because of sickness or injury are set in flat rates with definite sums added for dependents. The exact schedule is not yet arranged, however, the maximum benefits and the maximum dependents' allowances will not exceed 75 to 80 per cent of wages earned in any group. 20 weekly contributions in the year preceding his disabling illness or 32 within the preceding two years must have been paid by the worker before he may receive cash benefits and he must submit to a waiting period of seven consecutive days.

Medical Benefits.

While on the job the worker and his dependents will at all times be entitled to medical care. This includes the services of a general practitioner, ante partum and maternity care, specialist care found necessary by the general practitioner, dental care, laboratory and clinic care recommended by the general practitioner, and hospital care. General practitioner's services would be available 26 weeks out of 52, specialist and laboratory 12 weeks. Hospitalization to workers and dependents would be free for the first three weeks but during the following three months there would be a small percentage charge. If funds are adequate the duration of regular benefits may be increased and additional medical benefits, such as drugs and nursing services, added. No waiting period is required for medical care. The maternity patient, in addition to her medical care, will be entitled to maternity cash benefits for six weeks both before and after the birth of her baby and a small cash bonus in addition, provided she has taken advantage of the ante-partum care.

Physicians In Control.

The bill makes a radical change from the 1934 draft by assigning the policy making and supervisory functions to a board representing employers, workers and the professional groups participating in the program and the administrative functions to a commissioner of health insurance, who would also be chairman of the board. This follows the plan of the Social Welfare Board now in operation in New York State. Locally, the administration would be in the hands of Councils consisting of representatives of employers, workers and the professions, aided by whatever special professional advisory committees may be found necessary. Medical referees for medical problems and regular referees for financial problems would be selected by and responsible to an appeal board appointed by the Governor.

Free Choice of Physicians.

All duly licensed physicians "and other practitioners" as well as groups of such practitioners would be able to participate in the system. Workers would choose their physician from a panel list and any practitioner might reject any patient.

The method of renumeration of the physician would be decided in each locality, whether it be based on a salary system, a per capita system, a fee system, or any combination of these systems.

The New York State Journal of Medicine believes that "the present moment is singularly inopportune for the adoption of a controversial measure like compulsory sickness insurance." Methods of voluntary health insurance are springing up all over the country and government economy can scarcely be burdened at this time with such a financial load as compulsory sickness insurance. Such a bill as the American Association for Social Security hopes to force through the legislatures of this year raises a distinct threat to physician and layman alike.

Participating in the recent conference of the Association for Social Security were Professor L. Wight Bakke of Yale University, Doctor John P. Peters of Yale University School of Medicine, and Miss Jeannette Studley of the Consumers' League of Connecticut.

☆☆

NATIONAL HOSPITAL DAY TROPHY

The New England Sanitarium and Hospital, one of the regular advertisers of the Journal, was awarded the National Hospital Day Trophy at the convention of the American Hospital Association held in Toronto in September. This trophy, awarded by Parke, Davis & Company, another one of the Journal's advertising friends, was given to the New England institution for the third consecutive year for the best educational program conducted by the hospitals of America in connection with National Hospital Day. The trophy is now the permanent property of the recipient.

☆☆

REVISED NURSE PRACTICE ACT

(*Concluded from Page 63*)

that these organizations employ about 500 people to care for their patients, (the approximate ratio being probably about 150 graduate nurses and 350 attendants). Also included in the recent requirements for licensing are the individuals employed as nurses in schools, doctors' offices, camps, and in industry.

To date,* 1300 applications have been sent out for certification under the waiver. Four hundred forty-one applications have been returned, of which 334 are acceptable, 38 have been refused, and 69 are pending. Each application requires considerable correspondence, and in many instances, also a conference for the proper completion of the blank. One of the major problems has been the matter of establishing proof of citizenship. Incidents arise, some of which are tragic and some of which are humerous; but needless to say, they are all very time-consuming. Of course, the only professional endorsement which the law requires is two doctors' signatures on each application. We hope, therefore, that the physicians are carefully considering this responsibility before they sign applications and that if the individual should not be licensed as a trained attendant, that the doctor will refuse to endorse the application.

A waiver for any group is, of course, a compromise measure, and those who will be certified after July 1940, will be required to have completed a course approved by the Board. As members of the professional groups having sponsored this legislation, it is important for us to consider the level of preparation necessary for the individuals caring for the aged and for the convalescent, as well as studying the number of individuals being prepared to meet this community need. Since the latter is necessarily time-consuming, this seems a pertinent item which we should study carefully at this time.

*Nov. 17, 1939.

-The- General Practitioner's Forum

Sulfanilamide and its derivatives have become indispensable cohorts in the battle against disease. However, these powerful drugs are potentially dangerous, and to avoid serious consequences accurate knowledge of the toxic reactions is desirable. The following summary of these reactions is up-to-date and authoritative.

Mild toxicity — anorexia, nausea, headache, dizziness, slight cyanosis, mild dyspnea. These are not serious and may be disregarded.

Moderately severe toxicity — vomiting, diarrhea, epigastric pain, marked cyanosis and dyspnea, acidosis, generalized pruritis, hemoglobinuria, progressive anemia and leukopenia. Constant observation is necessary and a reduction of the dosage may be required.

Serious toxicity — fever, rash, acute hemolytic anemia, agranulocytosis, jaundice, delirium. Immediate withdrawal of the drug is imperative and active treatment of the condition instituted. Recommended therapy — force fluids by all routes, glucose intravenously, insulin by hypodermic, transfusion, pentnucleotide 40 cc. daily, methylene blue both intravenously and by mouth.

Incidence of toxic symptoms may be reduced by observing the following suggestions. Close supervision of the patient, force fluids, frequent blood counts, except for codein, morphine and sodium bicarbonate give no other medication. Especially prohibited are the saline sulphates. Avoid giving the drug to patients with kidney or liver damage but if it is necessary to use it, give smaller doses.

* * * *

Vitamin K is now having its day in court. Some known facts about it are as follows: it is fat soluble and found most abundantly in alfalfa, spinach and decomposing fish. It is activated or synthesised in the human large intestine by bacterial action. Deficiency is manifested by lowered prothrombin content of the blood and the tendency to hemorrhage. Best results are obtained by giving it orally combined with bile salts or bile acids. One capsule of the vitamin daily for two or three days is sufficient preoperative preparation. The danger of thrombus formation may be discounted.

* * * *

In a paper read before the Children's Surgical Conference at Bellevue Hospital, Delaney reviewed the end results in the treatment of gastro-intestinal foreign bodies in children. Over a period of ten years there were 41 admissions to the service. The objects swallowed included all the usual things sharp or dull, flat, round or irregular. One child had swallowed a celluloid doll's head about 1½ inches in diameter.

Striking facts were that all were eliminated by the usual route, longest elapsed time without ill effects one month.

Treatment was simple. Constant medical supervision, regular diet, no cathartics and periodic check-up by x-ray. If the family gets uneasy a placebo may be given.

* * * *

The following quotation speaks for itself. "For my part I am still unconvinced that the family doctor is an anachronism. I still want somebody to save me from unsuitable or excessive specialist advice; I want someone to co-ordinate the findings of specialists and discount them if necessary; and above all I need someone who is willing to talk to me at length, about my migraine, my little boy's delinquencies, my wife's recent strangeness, my baby's inoculation, and my daughter's desire to marry a man with asthma." — Onlooker, Lancet.

* * * *

Vincent's angina-trench mouth and impetigo contagiosa are always with us. Both respond very nicely to small doses of sulfanilamide and local application of 2% genitan violet.

T. P. R., M.D.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES
for
PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

Our Neighbors

MAINE

The Journal of the Maine Association, January, 1940, contains a clinical study of the Treatment of Asphyxia Neonatorum. This study is based upon an expression of opinion received from the Professor of Obstetrics of 63 American and Canadian Medical Schools. The material included will serve as an excellent review of the subject and the comments and conclusions are well worth noting.

* * * *

MASSACHUSETTS

The State of Massachusetts has recently passed legislation which makes it possible to protect its citizens in medical affairs. Hitherto there has been no provision for examining candidates for licenses to practice medicine except by a written test—a method of determining competence considered inadequate by all other states. Now Massachusetts is requiring that those who take the licensing examination must be graduated from approved medical schools.

A board, which has the authority to formulate standards in medical education, has been organized and will pass on the qualifications of schools of medicine. Massachusetts is to be congratulated upon this step which raises the qualifications of its medical practitioners to the general level prevailing throughout the United States. Editorial, Jour. of Amer. Med. Assn.

* * * *

NEW JERSEY

The Medical Society of New Jersey, through its President, Doctor E. Zeh Hawkes, has objected strenously to the organization and activities of the National Physicians' Committee for Extension of Medical Services. It believes, according to a letter addressed to the Secretary of the A. M. A., that it is not necessary for the national organization to write and introduce health legislation at this time but merely to act in an advisory capacity with whatever agency is drafting such legislation. Public opinion will be won much more readily in this manner, this Society believes, and it cannot see how such advice and cooperation would incur additional taxation. To quote, "no amount of taxes saved can compensate the A. M. A. for the loss of public esteem."

* * * *

RHODE ISLAND

The Providence Medical Association presents Medical News, a monthly, non-scientific paper which "will attempt to present a digest of information and news of a medical economic nature, as well as provide a medium for the listing of local medical news items which might otherwise escape the attention of the profession." Appearing in its first five numbers as a mimeographed news letter, No. 6, is a very readable printed sheet of eight pages. With the appearance of Medical News we are reminded that just forty years ago a quarterly known as the Provdence Medical Journal first made its appearance. In 1917 this publication became the Rhode Island Medical Journal. Freedom of thought and freedom of speech, so prominent in 1774 in Providence where a Continental Congress was first proposed for the union of the colonies, are still revered as the basis of democracy by the physicians of that city.

Physicians of Rhode Island are contemplating petitioning the Registry of Motor Vehicles for the use of "MD" on their auto license plates. New York State has adopted and used this distinguishing mark for its physicians for the past two years. The members of the Medical Society of the State of New York are said to like it.

A series of Obstetrical Conferences are being held at the Providence Lying-In Hospital on Wednesdays at 11:00 a.m. during February and the first Wednesday in March. Each speaker is limited to 20 minutes and there is one half hour allotted for round table discussion. The Conferences are being offered by the Rhode Island Medical Society and the Division of Maternal and Child Health of the State Department of Public Health.

Doctor and Mrs. Dennett L. Richardson were tendered a testimonial dinner on December 14, 1939, by the resident staff and employees of the Charles V. Chapin Hospital. Doctor Richardson is retiring from the superintendency of the hospital after thrity years of "untiring effort and unselfish loyalty to this institution."

- NEWS -

from County Associations

Fairfield

The Danbury Hospital is looking forward to the early opening of their new wing, which in addition to accommodations for private patients will have the best in operating and obstetrical suites, a new X-ray department, laboratories, kitchens and last but not least, a new power house.

The December meeting of the Bridgeport Medical Association was addressed by Doctor Murray H. Bass, Assistant Clinical Professor of Pediatrics at Columbia University. Doctor Bass gave an interesting argument for the use of continuous venoclyses and spoke enthusiastically of results obtained with convalescent sera, especially in streptoccal infections.

Early in January the members of the Bridgeport Medical Association received from their jovial Secretary, Doctor Ellwood C. Weise the announcement of the Sixty-ninth Annual Banquet of their Society, to be held at the Algonquin Club on Tuesday, January sixteenth. High Potency Cocktails — U. S. P. were first on the agenda, then a brief special meeting of the association for minor matter various, after which a direct approach to the more serious affair of the banquet, prepared as only the chefs at Algonquin know how, flanked and interlarded by bits, tidbits, and morsels of juicy entertainment; Jest and youthful Jollity, Quips and Cranks and wanton Wiles, Nods and Becks and wreathed Smiles, with no appologies to Doctor Milton.

On February sixth, Doctor Hugh Auchincloss will continue the symposium on Infection before the County Association with a paper on, "Wounds — Treatment and Complications" at the University Club in Bridgeport. On March fifth, Doctor Russell L. Cecil of New York will talk on "Pneumonia" at the same place. A week later Doctor Cecil will again give a paper in Fairfield County, this time at the Stamford Hospital on "Principles of Serological Treatment."

On December 27, 1939 Doctor Charles A. Murphy of Stamford, and Mary F. Ryle, daughter of Mrs. Anna Graham Ryle and the late Doctor John J. Ryle, were married at St. John's Roman Catholic Church in Stamford.

On January first Doctor George W. Hawley, inventor of the Hawley Fracture Table and noted opthopedic surgeon, died at his home on Long Lots Road. Several years ago Doctor Hawley had been forced to retire from active practice, but continued an alert interest in medical affairs. In collaboration with others he was an active contributor to orthopedic literature almost to the time of his death. He was particularly liberal of his time and encouragement to younger men in medicine.

On December 20, 1939, Doctor Alfred F. Hewitt of Stamford died after a short illness.

Doctor W. D. Hoffecker of New Canaan died recently. Doctor Hoffecker formerly practiced in Bridgeport and at that time was a member of the Bridgeport Medical Association.

* * * *

Hartford

Newly elected officers of the Hartford Medical Society are as follows:

President—Arthur B. Landry
Vice-President—Albert R. Keith
Secretary—David Gaberman
Assistant Secretary—Ralph T. Ogden

Re-elections were as follows:

Treasurer—Franklin L. Lawton
Assistant Treasurer—Clinton D. Deming
Librarian—Walter R. Steiner
Assistant Librarian—Ernest Caulfield
Howard W. Brayton was elected a trustee.

The retiring President, Doctor Howard W. Brayton, gave an extemporaneous address which concerned the value of the Medical Society as an organization to aid its members in various ways connected with medical practice. He particularly urged the continuance of the Society as a medium of brotherhood among the members. The talk was very scholarly and well received.

The Programme Committee of the Society intends to carry out the intention of previous committees in having the best of post-graduate instruction obtainable. Some of the meetings for the near future might be listed. On February 5, the topic will be "Urinary Obstruction from the Point-Of-View of the Family Physician" by Doctor George F. Cahill of New York. On February 19, a talk on "Osteoporosis" will be given by Doctor Fuller Albright who has done considerable experimental work on this condition. On March 4 there will be an address by Doctor William Stroud of the University of Pennsylvania, Philadelphia, concerning, "The Effect of Gall-Bladder Disease Upon the Heart." The other meeting in March will be given over to Doctor William P. Murphy of Boston, one of the outstanding authorities on "Anemia." At this meeting it will be arranged to show some interesting movies on Pernicious Anemia.

Again attention is called to members of the County of the valuable facilities for post-graduate instruction in our own vicinity. Medical Clinics held at the Hartford Hospital on Tuesday at 12:40 and a Clinic held at St. Francis Hospital every Wednesday morning at 11:30 are particularly mentioned.

A large gathering of the members of the Hartford Medical Society was greatly benefited on the evening of January 15, 1940, by an illuminating address by Doctor Richard B. Cattell of the Lahey Clinic. Emphasizing his points by means of numerous lantern slides he gave a smoothly running discourse on "The Diagnosis and Treatment of Non-Malignant Lesions of the Large Bowel." It was an outstandingly valuable presentation.

On January 15 at the regular meeting of the Medical Society the following were elected to active membership:

Alfred L. Burgdorf
Christopher W. MacMinigal
Louis D. Harris
George J. Rosenbaum

The following was elected to associate membership:

Donald A. Bristoll

Congratulations to Doctor and Mrs. A. W. Branon on the birth of their son, David Reid, on January 15.

* * * *

Litchfield

The quarterly meeting of the Torrington Medical Society was held at the Charlotte Hungerford Hospital on Wednesday evening, January 3. Doctor Clarence Robbins of the Department of Medicine of the Yale University School of Medicine discussed the "Recent Advances in the Treatment of Pneumococcus Pneumonia." Doctor Robbins' talk was illustrated by lantern slides. Following this lecture Doctor Edward Roberts, representative of the Lederle Laboratories Inc., showed a new colored film describing the diagnostic and therapeutic measures employed in the treatment of pneumonia at the New York Hospital. This program was arranged by the Executive Secretary of the Connecticut State Medical Society.

Doctor Gilbert Hubert has announced the opening of his office for the practice of Pediatrics at 16 Litchfield Street, Torrington. Doctor Hubert was graduated from the Yale University School of Medicine in the class of 1935 and after interneship at Long Island College Hospital, he spent three years in the Department of Pediatrics at the Albany General Hospital. At present, Doctor Hubert is a clinical instructor in Pediatrics at Yale.

The Monthly meeting of the Tumor Clinic of The Charlotte Hungerford Hospital was held on January 3. Pathological material from a rare and unusual case of Echinococcus Cysts of the Myocardium was presented by Doctor Bradford Walker at this time.

The Annual meeting of Incorporators and Members of The Marie Seymour Brooker Memorial, Inc., was held at its office, 157 Litchfield Street, Monday, January 15. The President, Frank M. Travis, presided. Reports by Miss Harriet Parker, Supervisor, and John M. Wadhams, Treasurer, were submitted and accepted. The following persons were elected to succeed themselves as managers for a period of five years: Mrs. R. C. Swayze, Mr. H. Blake Fuessenich and Mr. William A. Gleeson. Mr. F. Earle Coe was elected to the Board of Managers to fill the vacancy of the class of 1939 created by the death of Mr. Frank Appelt.

The regular monthly meeting of the Charlotte Hungerford Hospital Auxiliary was held in the auditorium of the Memorial Home on Tuesday, January 16, 1940.

* * * *

Middlesex

Doctors Charlotte Walker and Daniel D. Lovelace have recently joined the staff of the Connecticut State Hospital in Middletown.

Doctor Bernard Brody, attending neurosurgeon at the Grace and St. Raphael Hospitals in New Haven, addressed the Central Medical Society on January 8 on "The Treatment of Head Injuries."

The Middlesex Hospital in Middletown recently announced that Doctor Harold E. Speight, Senior Attending Physician and Cardiologist, had been granted a year's leave of absence. He will leave on February 1, 1940, foi Boston, Mass., where he will do post graduate work in Internal Medicine at Harvard University and the Massachusetts General Hospital.

* * * *

Tolland

Under Middlesex County News in the January 1940 issue appeared an error to the effect that Doctor J. Henry Colomb, who until recently was clinical director at the Connecticut State Hospital at Middletown, has taken a position as assistant superintendent at the Mansfield School. The corrected item as verified by Superintendent Chaıles T. LaMoure, M.D., should read as follows:

Doctor Walter C. Haviland, a physician on the staff of the Connecticut State Hospital in Middletown, left December first to become senior physician at the Mansfield State Training School and Hospital at Mansfield Depot.

☆☆

THE ABBOTT ESTATE GIFTS

Gifts of approximately $1,500,000 to Northwestern University and of approximately $1,000,000 to the University of Chicago are announced by the Trustees of the Estate of Clara A. Abbott, who died in 1924, and whose will made unusually generous provision for charity. The Estate is now finally closed.

Both gifts will be used for medical and chemical research.

The gift to the University of Chicago will operate to secure for that Institution an additional $1,500,000 from the Rockefeller Foundation to be used for Biological Research which was promised conditionally upon the University securing an additional amount now realized by the Abbott Estate gift.

Clara A. Abbott was the widow of Dr. Wallace C. Abbott, Founder of Abbott Laboratories. The latter was a practicing physician in Chicago for many years and began the manufacture of chemicals and pharmaceuticals in Ravenswood, Ill., in 1888. He died in 1921.

Other gifts also announced by the Trustees include the following approximate amounts to the following institutions: Victory Memorial Hospital, Waukegan, Ill., $250,000; Evanston Hospital, Evanston, Ill., $250,000, and Knox College, Galesburg, Ill., $250,000.

"Both Doctor and Mrs. Abbott were intensely interested in research work in colleges and universities. These gifts will enable the recipients to carry on their work still more efficiently for the benefit of mankind," Alfred W. Bays and H. B. Shattuck, the Trustees, stated in the announcement.

☆☆

BANANA RANKS HIGH IN CALORIC VALUE AMONG FRUITS

The banana has a greater caloric value than any other fresh fruit except the avocado, Harriet Morgan Fyler, Ph.D., Chicago, points out in *Hygeia, The Health Magazine* for October.

"A banana is about one fifth carbohydrate," she says. "When the fruit is fully ripe, this is practically all sugar. A medium sized banana yields about 100 calories, equivalent in food energy to twenty grapes, four dates or a cupful of orange juice.

"Bananas are a good source of vitamins A, B^1, C and G (riboflavin) and contain small amounts of important minerals, including calcium, copper, iron and phosphorus.

☆☆

Pulmonary tuberculosis in syphilitic patients does not respond as favorably to sanatorium treatment as does the disease in non-syphilitic patients but the course of syphilis in the tuberculous patient does not appear to differ from the course of the disease in the non-tuberculous. Warring, F.C., Amer. Rev. of Tuber., Aug. 1939.

The PROFESSIONAL EQUIPMENT Co. X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS. TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

SPECIAL NOTICES

CONNECTICUT MEDICAL EXAMINING BOARD

Written Examination	March 12 and 13, 1940
Credential Examination	March 26, 1940

☆☆

PROGRAM OF THE NEW ENGLAND PEDIATRIC SOCIETY

February 7, 1940

4:00-5:30 P.M. Clinical Meeting, The Children's Hospital Ampitheatre.

5:30-7:00 P.M. "Refreshments" at Longwood Towers, Brookline, Mass.

7:00 P.M. Dinner at Longwood Towers, Price $1.50.

8:00 P.M. Business meeting.

Symposium: Treatment of Meningitis.

1. Treatment of Epidemic and Streptococcus Meningitis, Josephine B. Neal, M.D., New York City, N.Y.
2. Treatment of Pneumococcus Meningitis, Maxwell Finland, M.D., Boston City Hospital.
3. Treatment of Influenzal Meningitis, LeRoy Fothergill, M.D., Harvard Medical School.
4. Discussions: Kenneth D. Blackfan, M.D., The Children's Hospital.

R. Cannon Eley, M.D., *President*
James Marvin Baty, M.D., *Sec.*

☆☆

POSTGRADUATE COURSE IN SYPHILIS

The next session of the Postgraduate Course in Syphilis at New York University College of Medicine will start on January 2: and will continue for eight weeks on a full-time basis. As the work will be given under grants from the United States Public Health Service and the New York State Department of Health, no tuition fee is to be charged.

The course will include didactic and clinical work in the pathology, diagnosis, and treatment of syphilis, prenatal and congenital syphilis, laboratory procedures, and control measures. The public-health aspects of the disease will also be presented, and there will be opportunity for field work.

Graduates of recognized medical schools are eligible for admission on approval by the committee in charge. Further details may be obtained from the office of the assistant dean, 477 First Avenue, New York, N. Y.

POSTGRADUATE COURSE IN RADIATION

A new part time postgraduate course in radiation therapy which is to begin on January 29 and continue for four months is announced by the New York University College of Medicine.

The course will comprise the physical and biological basis of radiation therapy, the basic pathological changes produced by radiation therapy including the determination of radio-sensitivity, the grading of neoplasms, and the study of the practical methods of radiation therapy. The theoretical portion of the course will be given at the College of Medicine and the practical work at Bellevue Hospital.

The course is open to radiologists and others specially qualified. For further information apply to the Office of the Dean, 477 First Avenue, New York City.

☆☆

INTERNATIONAL COLLEGE OF SURGEONS

The Fifth Assembly of the United States Chapter of the International College of Surgeons will be held at the Florida Medical Center, Venice, Florida, February 11 to 14, inclusive. All members of the medical profession in good standing are cordially invited. The program includes a number of papers by eminent surgeons, round table discussions, social events, scientific exhibits, motion pictures and commercial exhibits. Doctor Fred H. Albee, Chairman of Arrangements, will be pleased to book accommodations for any one by request.

☆ ☆ ☆ ☆

FOUNDING OF MEDICAL SOCIETY OF SOUTH CAROLINA

On December 5, South Carolina physicians celebrated the 150th anniversary of the founding of the Charleston Medical Society, a state wide organization until 1848 when the South Carolina State Medical Association was formed. This Charleston Society is one of only about six medical societies in the United States which have been in continuous existence. Many prominent medical men from far and near were present on this occasion. It will be noted that this society antedated our own State Society by three years.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

• OBITUARIES •

EDWARD AUGUSTUS STRATTON, M.D.

1862-1939

Doctor Edward Augustus Stratton, dean of the medical fraternity of Danbury, died at his home 112 Liberty Street, July 9, 1939. Although he had been failing in health several months he was confined to his bed only a week. His death ended a career of more than half a century, in which he was identified with the medical life of Danbury and surrounding communities, and removed a man who had a wide influence in the profession of medicine and surgery.

Doctor Stratton was recognized as one of the leading surgeons of Connecticut, a position he gained through his intensive application from the days of his early practice and by his readiness always to take advantage of the latest developments in the fields of surgery and medicine.

In his long practice, Doctor Stratton maintained his office alone, until 1927 when Doctor John D. Booth became associated with him, that affiliation continuing until Doctor Stratton's retirement in 1937.

One of the most pleasing events in his life was the testimonial given him by the medical fraternity of Danbury, June 6, 1934, on the occasion of his fiftieth year as a doctor.

Doctor Edward Augustus Stratton, the son of George and Emma Jane Davis Stratton, was born in Danbury, Nov. 8, 1862. He attended the public schools and graduated from the Danbury High School. At the age of nineteen he began the study of medicine with a preceptor, Doctor John H. Benedict, and later studied at the School of Medicine of the University of New York, from which he graduated in 1883. Following his graduation he was associated for a short time with Doctor Benedict. Doctor Stratton from the beginning of his practice had a particular interest in surgery and his colleagues always regarded him as one of the pioneers of surgery in his section of the State. He was actively identified with the Danbury Hospital from the time of its founding and was one of the first surgeons appointed to the staff. He remained in active surgical practice until 1937 when he resigned from the surgical staff and became a consulting surgeon to the hospital. Doctor Stratton's fame as a surgeon was not only local, but he was continually called upon by physicians in surrounding communities for surgical consultation. He never accepted office in either medical or civic life with the exception of the appointment as Medical Examiner. He was the first appointee for New Fairfield and about five years later was advanced to the position of Medical Examiner for Danbury and rendered a most outstanding service to the community and county in this position until his resignation about three years ago. Doctor Stratton was a member of the Danbury Medical Society; Fairfield County Medical Association; Connecticut State Medical Society; American Medical Association; New York Academy of Medicine; and Fellow of the American College of Surgeons. He also was a member of Union Lodge, F. & A. M. and other Masonic bodies of Danbury, including Crusader Commandery, Knights Templar; and of Pyramid Temple, Mystic Shrine.

He was a charter member of the Ridgewood Country Club and also a charter member of the Danbury Club.

He was married on December 28, 1921, to Flora Hollister Schuldice, of Danbury.

ALFRED FRANK HEWITT, M.D.

1891-1939

On Wednesday, December 20, 1939, our esteemed associate Doctor Alfred Frank Hewitt passed away. His death at the time of his greatest usefulness is indeed a loss to Stamford, but we who were associated with him for many years mourn a true friend and brother physician who exemplified the highest ideals of our profession.

Doctor Hewitt was born in Stamford on July 11, 1851. His education in the Stamford public schools was interrupted at the age of sixteen by the removal of his family to Syracuse, N. Y., where he graduated from the Travis Preparatory School in 1909. He then entered Syracuse University and received the degree of Doctor of Medicine in 1913. After an interneship at St. Joseph's Hospital, he went to Rochester, Minnesota, where he engaged in the practice of medicine for one year.

Returning to Stamford in 1917, Doctor Hewitt decided to make this city his home again and accordingly started to follow his chosen calling. This was interrupted when he served in the Army Medical Corps as First Lieutenant during the World War.

In June, 1918, Doctor Hewitt married Della Hasche. To them were born two sons and a daughter, all of whom survive.

Always keenly interested in the activities of the Stamford Hospital, he conducted the first clinic when the Hospital started that service in 1923. Of later years he was a member of the Surgical Staff.

At the time of his death he was a representative for Fairfield County in the House of Delegates of the Connecticut State Medical Society. In our local society, he served in many helpful and constructive capacities, and under his guidance as treasurer was started our reserve fund which has grown steadily. He was president in 1930.

Doctor Hewitt's activities were not only in the field of medicine. He was one of the first members of the Oscar H. Cowan Post of the American Legion, which he served faithfully for nineteen years and of which he was Commander in 1925. To quote the Stamford Legionnaire: "Let us all, new members and old, strive to keep alive the principles of Justice, Freedom, and Democracy so dear to all Americans. In the storm-tossed world of today, men of the calibre of Doctor Hewitt are sorely needed. We mourn our loss."

He was always interested in the growth and welfare of our town and for this reason, he took an active part in local politics, being a member of the Republican Town Committee for many years. He was also a past president of the Kiwanis Club.

Doctor Hewitt had been in poor health for a year. He carried on with magnificent courage and an indomitable will, working until within three days of his death when his heart failed him. This was typical of the man, who never of robust physique, labored for others seeking only to be of service. He had an altruistic idea of the practice of medicine, ever being governed by a sense of duty to his patients. No matter how humble they were, he gave unstintingly of his time and fine skill. With a keen sense of humor he always met life with a kindly good-natured smile, and to his friends who were many he was loyal and devoted.

Robert M. Carpenter, M.D.

⁂

COMING MEETINGS

February 6 — 8:30 p.m. Fairfield County Medical Association, University Club, Bridgeport. "Wounds-Treatment and Complications"—Hugh Auchincloss, New York.

March 5 — 8:30 p.m. Bridgeport Medical Society, University Club. "Pneumonia" — Russell L. Cecil, New York.

March 12 — 8:30 p.m. Fairfield County Medical Association, Stamford Hospital. "Principles of Serological Treatment" — Russell L. Cecil, New York.

May 14 — 8:30 p.m. Fairfield County Medical Association. Pickwick Arms, Greenwich. "Modern Trends in Chemotherapy" — Francis G. Blake, New Haven.

May 22-23 — Connecticut State Medical Society, Hotel Bond, Hartford, Annual Meeting.

⁂

MALIGNANCY IN CHILDREN

Ellis Kellert of Schenectady, N.Y. (N.Y. State Jour. Med., Dec. 15, 1939), reports the malignant tumors in children under 16 years of age at Ellis Hospital, Schenectady, over an eleven year period (1928-1938). There was a total of fifteen malignant tumors, representing a ratio in that hospital of 1 childhood tumor to 137 in adults. The list includes 1 fibrosarcoma of the foot, age 5 months; 1 myxosarcoma of the retroperitoneum, age 5 years; 1 osteosarcoma of the tibia, age 14 years; 1 gliosarcoma of the orbit, age 15 years; 1 giant cell sarcoma of the femur, age 15 years; 1 adenosarcoma of the kidney, age 2½ years; 1 Ewing tumor of the humerus, age 5½ years; 2 gliomas of the brain, one at 7 and the other at 12 years; 3 neurocytomas, 2 of the left adrenal and 1 of the right, 1 at 10 months, the other two at 2 and 2½ years; 3 carcinomas, 1 of the right adrenal at 2 years, 1 of the kidney at 8 years and 1 of the uterus at 11 years. The only patient alive in the whole group is the child who had a fibrosarcoma of the foot, treated entirely by radiation when this type of tumor is usually considered radioresistant.

• Quarto Notes •

THE PATIENT'S DILEMMA

by

Hugh Cabot, M. D.

284 pages $2.50
New York Reynal & Hitchcock, Inc. 1940

Doctor Cabot prefaces this volume with the statement that "no physician can be wholly without bias." He presents his qualifications as a proponent of what he pleases to call good medical care, viz., a conservative training over the first forty years of his life in the atmosphere of the New England Town meeting, the first twenty years of medical practice under the spell and tradition of the old Massachusetts General Hospital, a full time professor of surgery in and later dean of a mid-western Medical School, and, finally, ten years as consultant and teacher at the Mayo Clinic. But even these qualifications could serve but little to change the idiosyncrasies of a descendent of that renowned English family whose post prandial reputation has had no peer in stories of the Cabots who "talked with God."

With the author's desire to give voice to "the faith that is in me" we have no argument. He strays very little from the truth when he reminds us that all is confusion today in the economic plan of medical care. But where do we not find confusion in any social economic problem of the masses of this generation, so rapidly have the dominant forces of labor come to the fore and with such strides has our government felt obligated to take up the poor man's burden? Doctor Cabot's book is worth reading. To the thinking physician there is much that will arouse and perhaps anger but confession is good for the soul and the truth, though it hurts, is always better expressed. To the layman this volume may seem rather tedious in its review of diseases, not once but several times, yet it presents the problem from all sides and spares no one, true to the form of this particular Cabot.

The volume is predicated on that remark, now become famous, of the Editor of the Journal of the American Medical Association, Doctor Fishbein, that "obviously, 85 per cent of the diseases for which patients consult doctors are of the type which the general practitioner can handle with the amount of equipment that he can carry in a handbag." Doctor Cabot holds up to scorn "organized medicine" as represented by its national organization because of its seeming reactionary attitude. He gives the everyday doctor no credit for being a man slow of speech and slow to cast off the time honored customs for the new and untried. It is not amiss to remind Doctor Cabot's readers and our own that had there not been a sufficiency of the conservative element existing in our profession we might today find ourself saddled with a confusion of ill advised and unbalanced schemes for medical care which could serve but to add to that towering threat, the national debt.

To the credit of Doctor Cabot be it said that he subscribes to good medical care as distinguished from adequate medical care and to a definition of good medical care laid down by Doctor Roger I. Lee of Boston, viz., that it "is the kind of medicine practiced and taught by the recognized leaders of the medical profession." To Doctor Cabot's credit be it also granted that he presents in a fair and concise manner the larger problems involved in the present difficulty, viz., cost of medical education, sliding scale of fees, geographical distribution of medical care, the specialist, diagnostic adjuncts as the X-ray and the laboratory, financial problems of the hospitals, and the possibilities involved in placing physicians on a salary. He is a strong advocate of group medical practice. He is opposed to health insurance, whether voluntary or compulsory. He considers hospitalization insurance an "interesting experiment" and but a drop in the bucket in solving the difficulty and predicts that many now subscribers will drop from its rolls because they feel it superfluous. His solution of good medical care lies in government control through a General Medical Council or Commission with waste and extravagance reduced by group practice. Many of the principles which he advocates are now part of the platform of the American Medical Association, much of the detail may be found in the declarations of that well known "Committee of 430."

HARVEY CUSHING'S SEVENTIETH BIRTHDAY PARTY—APRIL 8, 1939

Speeches, Letters and Tributes

146 pages $3.00
Published for the Harvey Cushing Society
Springfield, Ill. Charles C. Thomas 1939

"The day is short and work is great. The reward is also great and the Master praises. It is not incumbent on thee to complete the work but thou must not therefore cease from it." (From the Talmud).

How few who reach the Biblical age can justly claim such honors as were bestowed upon the greatest surgeon of this century, Harvey Cushing! As one of his admirers has said, "when we think of Harvey Cushing we think not only of roentgenology, of the special field of brain surgery which we created, or of the Riva-Rocci pneumatic cuff which he brought to the United States in 1901, thus inaugurating the clinical study of blood pressure in this country, but we think of much else. Cushing's Life of Sir Wiliam Osler, Cushing's extraordinary capacity to handle patients of all walks of life, his series of brilliant monographs x x x x x and, finally, those who have had the privilege of knowing him more intimately think of his extraordinary library to which he is adding."

The birthday party in New Haven on April 8, 1939, was an event of great significance. The modesty of the renowned surgeon and scholar colored his remarks on that occasion. To his assistants and colleagues he gave much of the credit for accomplishments which could be ascribed to his inspiration. The presentation of a bibliography of his writings produced both delight and embarrassment, "delight in the possession of such a unique volume, embarrassment from being more aware than you of my many past blunders, scientific and otherwise." The tributes from professional and lay friends and from a host of patients comprise many pages of most interesting reading. The editorial appreciations, and the "Notes on the Formative Period" when Harvey Cushing was a student and later surgical "House Pupil" at the Massachusetts General Hospital complete the picture and give to the reader the feel of the friendly hand and the sound of the encouraging voice and leave with him a measure of the fine spirit by which Harvey Cushing's friends came to know him.

This volume, published by one who was present at the birthday party, is a delightful tribute to the famous neurological surgeon. "Harvey Cushing has flown higher and sustained his flight more consistently than any of his medical contemporaries. One never thinks of him as 'grounded.' "

☆☆

THE COMPLETE GUIDE TO BUST CULTURE

by

A. F. Niemoller, S.B., M.A., B.S.

with a foreword by Edward Podolosky. M.D.

160 pages 7 illustrative pages
New York The Harvest House 1939

This is intended as a lay guide to preserve the health and beauty of the female breast. Niemoller is a nonmedical writer, who claims to be a "beauty scientist," and is the author of other books on female subjects. With reference to the breast, he discusses the value of posture, diet, brassieres, mechanical devices, plastic surgery and the dangers of quackery with its abuses. In a superficial way, diseases of the breast are considered. The style is dull. As the author intends, it is probably safe for home reference and advice.

J. A. Wentworth

☆☆

ANESTHESIA: NARCOSIS, LOCAL, REGIONAL, SPINAL

by

A. M. Dogliotti, M.D., Professor of Surgery, University of Modena, Italy.

Translated by Carlo S. Scuderi, M. S., M.D., F. A. C. S., Assoc. in Surgery, University of Illinois, College of Medicine.

Cloth price, $7.50
680 pages with 17 tables and 236 illustrations partly in colors.
Chicago S. B. Debour 1939

This book is excellently translated by Dr. Carlo S. Scuderi, will be a welcome addition to the library of those members of the profession who are particularly interested in anesthesia. It will also be valuable as a reference book for medical students. The text represents a major contribution to the American medical profession from an Italian author who has had fifteen years experience as a surgeon. However, in late years his interest in anesthesia has increased to a point where one may consider him first an anesthetist, then a surgeon.

The text is interestingly written and very well illustrated. Aside from various pieces of apparatus, all the graphs, drawings, and photographs are original. An interesting innovation is the use of photographs to illustrate various procedures in the field of anesthesia.

The book is divided into three parts. Part one is made up of three chapters dealing with historical background, central and peripheral pathways of sensibility, and the pathologic physiology of pain, the examination of the patient and preoperative care. If any faults are to be found with this section it is that the material is presented practically in outline form and there is no discussion of postoperative care from the anesthetists' point of view.

Part two consists of two chapters. The first discusses the General Physiopathology of Narcosis which is in turn sub-divided into a discussion of definitions, theories, pathways of administration, absorption, distribution and elimination, signs of anesthesia, stages of narcosis, accidents and complications of narcosis and their treatment. There will be some disagreement with the author in his use of carbondioxide in anesthesia. He states that "carbon dioxide should be used in cases of respiratory arrest secondary to apnea and respiratory collapse due to toxic action of the anesthetic. However it is advisable not to increase the content above 5% in the inspired air, *and at the same time* to give sufficient oxygen." One is interested in knowing just how much oxygen is "sufficient" and if it is sufficient, is it not possible that the oxygen and not the carbon dioxide is the more important, if not the actual therapeutic agent? The section on fire and explosion lags considerably behind present knowledge in this country. This is not entirely unexpected in view of the intense research on this subject being conducted in the United States. The second chapter describes various types of anesthetic agents, and the technic of their administrations. Inhalation anesthesia, rectal anesthesia, intravenous anesthesia and mixed (combined) anesthesia is discussed. Much in this chapter is of academic interest for American anesthetists. Pictures of apparatus used by foreign anesthetists are interesting.

Part three is the largest and most interesting section of the book. There is a general consideration of agents and rules of peripheral anesthesia. Good descriptions of methods for special local-regional anesthesia, are extremely well illustrated. A reader is able to visualize various procedures demonstrated on a patient and he may turn to accompanying photographs to see the same procedure indicated on a skeleton. Extradural and subarachnoid anesthesia are considered in detail including indications, contraindications, technic, accidents, complications and their treatment, without undue emphasis on theories. It is interesting that Pages, a Spanish military physician, is credited by Dogliotti with making the first few attempts to produce epidural lumbar anesthesia for many have looked upon the author himself as the originator of this technic. One can agree with Dogliotti as he says it was only after "our studies and our clinical and experimental research that it became possible to present an anatomic and a physiologic basis for this form of anesthesia which we call peridural segmentary anesthesia." The final chapter is devoted to a discussion of the selection of the various anesthetic procedures in surgery which is on the whole authoritative and sound.

In summary, one may heartily agree with Prof. Ottorino Uffreduzzi that this first Italian treatise on anesthesia is written by an outstanding author, trained first in surgery, who has devoted much time to the study of anesthesia and has in this volume presented anesthesia as a fundamental science. This work will be of particular value and interest to American anesthetists and surgeons. Internists will find it worthy of their study because it contains valuable information regarding the pathogenesis and symptomatic treatment of pain.

J. H. Fine
R. M. Tovell

☆☆

OPERATIVE ORTHOPEDICS

by

Willis C. Campbell, M.D., Professor of Orthopedic Surgery, University of Tennessee

1154 pages 845 illustrations with 4 color plates $12.50
St. Louis, Mo. C. V. Mosby Co. 1939

Dr. Campbell's new book on "Operative Orthopedics" has been long awaited, in view of the fact that the last preceding textbook of orthopedic operations was published nearly fifteen years ago. That the field of orthopedics has advanced and enlarged is indicated by the fact that our present book is about three times the size of its predecessor. The author is a man of wide experience who brings much personal touch to this work as well as recognizing and appraising the work of others. Before touching on surgical technique, there is a well grounded chapter on the Physiology and Pathology of Bones and Joints. A very valuable chapter, discussing surgical approaches, is well illustrated with diagrams. A subject concerning which the Memphis group has written many articles and contributed much is that of arthroplasty so that it is with great authority that the technique of restoring motion to joints is described. That their methods are satisfactory has been well attested over the years by their end results.

With regard to fractures, there have been several very authoritative textbooks written in recent years which very adequately cover this field. Dr. Campbell has, of course, made many personal contributions to this field but this section adds an additional two hundred pages which might be left to the textbook on fractures, thus making our orthopedic textbook somewhat more readily handled.

The surgery of bone tuberculosis is well discussed, which work in this locality is becoming more and more confined to institutional cases. It is interesting to note that the treatment of congenital deformities, which in the early days of orthopedic surgery occupied such a large place, is left for a relatively short chapter at the very end of the book. It is truly an indication that the orthopedic surgeon also has become a traumatic surgeon.

Dr. Campbell's book is one in which no one interested in this field will be disappointed and its appearance is very timely. We may well recommend it.

M. M. Pike

ENDOCRINE GYNECOLOGY

by

E. C. Hamblen, B.S., M.D., F.A.C.S.
Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine.

453 pages $5.50
Springfield, Ill. Charles C. Thomas 1939

In the foreword to this volume Doctor J. B. Collip, Gilman Cheney Professor of Biochemistry and Pathological Chemistry at McGill University, informs the reader that Doctor Hamblen's work has been prepared not for the specialist but for the general practitioner. The results of extensive laboratory investigations of recent years on problems of sex physiology are interpreted to the clinician. That the volume is timely no one can deny. With the appearance on the market of many chemically pure hormones or extracts of hormones there is a great temptation afforded the general practitioner in particular to utilize any and all such within his reach, guided by the literature supplied by the commercial firm or the statements of the firm's representative as his manual of treatment. To all such, we beg of you, take this volume on Endocrine Gynecology, sit down with it and read it from cover to cover, then study it, and when you have finished you will begin to realize the vastness of this field and the uselessness as well as the dangers of shot gun endocrine therapy. Even to the specialist in gynecology this book should be of inestimable value, with the author's results in his own clinical cases tabulated and a correlation established between the newer knowledge of sex physiology gained largely in the laboratory and its clinical application to the treatment of human disease.

The format of the volume is very attractive and makes it very readable. Divided into three parts, it presents in the Introduction a discussion of Sex Endocrine Principles. In Part II is discussed Gynecic Physiology, dealing with the three periods in a woman's life, (1) ante natal, post natal and adolescence, (2) sexual maturity, and (3) the climacteric. Part III deals with the pathological results of disturbances in endocrine gynecology, the diagnostic procedures employed, the various sex syndromes found, abnormalities of growth, irregularities of uterine bleeding the abnormal menstrual symptoms, functional sterility, gestation and complications of the climacteric. Each chapter is accompanied by an exhaustive list of references, as many as ten or eleven pages long in some instances. The cuts are excellent and there is present a generous supply of instructive charts and tables.

The chemical origin of the hormones is explained and their relationship to the vitamins described. The various units of measure for estrogenic substances are elucidated. The origin and action of progesterone and of the androgens are dealt with, and the place of the hormones in the prevention of abnormalities of growth thoroughly reviewed. Anovulatory menstrual bleeding and the use of the pregnanediol complex in determining ovulation are discussed in detail. The discussion of the various endocrine syndromes due to pathology in different organs is especially to be commended.

Dr. Hamblen's book is the most complete of its kind yet to appear in the United States. It has successfully woven together so many of the loose ends in this field and at the same time will probably leave the majority of readers appalled at their own feeble grasp of the entire subject. The value of the volume is enhanced by so much clinical material in the hands of the author.

* * *

ACCEPTED FOODS AND THEIR NUTRITIONAL SIGNIFICANCE

Containing Descriptions of the Products Which Stand Accepted by the Council on Foods of the American Medical Association on September 1, 1939

492 pages
Chicago, Ill. American Medical Association 1939

In this age of high-powered advertising, it is often difficult to evaluate the claims that manufacturers hold for their products. In the field of nutrition this is particularly true because of a multitude of recent discoveries about food factors necessary for health and growth. Utilization of information concerning vitamins, minerals, calories, etc. has become a standard practice in advertising copy. Even though new laws are trying to force truth into the claims of manufacturers for their products, it is still difficult to choose reliable ones from the large field presented to the public.

This book, put out by the Council on Pharmacy and Chemistry's Committee on Foods, is an attempt to present the decisions of the best authoritative opinion concerning food and nutritional values. Their reports are also published in the *Journal of the American Medical Association* and represent a tremendous amount of labor and expense. Of particular interest in this book are the criteria used by the Council in determining whether or not a particular food substance should be accepted, and their policies in regard to advertising claims. There is an exceptionally good chapter on infant foods.

Two limitations, however, to this splendid book are evident. In the first place, not all products are submitted for approval, so that a great many brands which might be entirely acceptable have not been listed. Secondly, the manufacturers and producers change their methods and their advertising copy so rapidly and so frequently that facts which were true at the time of investigation may be entirely different by the time of publication of the report.

In spite of these two limitations, this volume will be very useful to practicing physicians and dietitians in helping them to evaluate food manufacturers' claims and to choose reliable food products.

W. F. S.

* * *

HEALTHY BABIES ARE HAPPY BABIES

by

Josephine Hemenway Kenyon, M.D.

348 pages Revised edition $1.50
Boston, Mass. Little, Brown & Co. 1938

This book is presented for the layman as a sort of handbook on ante and post partum care of the mother and neonatal and early childhood care of the child.

The book is divided into nineteen chapters — one,

FIRST AID FOR ENJOYMENT!

To sit and sip a Johnnie Walker and soda is to know the true enjoyment of a really great Scotch. For there's no finer whisky than Scotch and Johnnie Walker is Scotch at its smooth, mellow best!

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

RED LABEL
8 years old
BLACK LABEL
12 years old
Both 86.8 proof

BORN 1820 . . .
still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE

Wyeth

Has shown a CONVINCING RECORD* OF EFFECTIVENESS in ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae • Trichomonas vaginalis Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

"Before the Baby Comes," devoted to ante partum care of the prospective mother and preparation for the reception of the new patient, one to "Common Communicable Diseases of Childhood," and the last to "Emergencies." The remaining sixteen chapters describe the child's mental and physical state and appropriate care and feeding technique at various stages of expected significant change in growth and development up to four years. Each chapter starts or ends with several paragraphs on maternal post partum exercises and care at the time under consideration. The remainder of the chapter is devoted to description of physical and mental development of the child, his care and the technique of his feeding. Considerable stress is laid on passive exercises which grow more complicated as age advances.

The writer advocates breast feeding up to six months. When this is not possible her first choice is certified raw milk but the preparation of various whole, evaporated and lactic acid milk mixtures is thoroughly described. Solid food in the form of boiled vegetable juices and thin pastes is added slowly and in small quantities after the second month. The various vitamins are considered and cod liver oil or its equivalent and orange juice or cervitamic acid are added at one month. The whole technique of infant and child feeding including that of premature infants is exhaustively considered.

The chapter on "Communicable Disease" contains brief summaries of the common and uncommon infectious diseases in tabular form. Source of infection, incubation period, symptoms at onset and obvious signs are described for each.

Other subjects considered in complete detail are clothing for the child, furnishings for the child's room, constipation and care of the bowels.

The book contains a vast amount of information and it seems that almost every conceivable question arising in a mother's mind is answered. The book is indexed fairly completely. The nature of the material presented is essentially the same as that in the booklet. "Infant Care," published by the United States Department of Labor.

D. F. Harvey

* * *

VACCINATION AGAINST PUERPERAL INFECTIONS

A report of a series of 228 pregnant women vaccinated puerperal infection appears in the August issue of the Pennsylvania Medical Journal. The vaccine used was composed of streptococcus hemolyticus 35%, streptococcus viridans 15%, staphylococcus aureus 15%, B. coli communis 15%, streptococcus nonhemolyticus 10%, staphylococcus albus 10%. The total number of injections at weekly intervals varied from 5 to 29. All the 228 patients were delivered without any fatalities. The puerperal morbidity was 5.4% as compared to the morbidity of the non vaccinated cases which was 19.2%.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1939-1940) . . . 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) . . . 5

ORIGINAL PAPERS:

Acute Laryngotracheobronchitis — Paul B. MacCready, M. D., New Haven, Conn. 123

Psychiatric Approach to Problems in General Medicine — James H. Wall, M.D., White Plains, N. Y. 127

Modern Methods in Treatment of Pneumonia — Chester S. Keefer, M.D., Boston, Mass. 131

Treatment of Pneumonia — Louis H. Nahum, M.D., New Haven, Conn. 135

Short Cyclopegia for Refraction — S. Judd Beach, M.D., Portland, Maine 140

ASSOCIATION OF CONNECTICUT TUMOR CLINICS:

Fourteenth Meeting held at Lawrence and Memorial Associated Hospitals, Inc., New London, November 3, 1939 . . . 142

STATE DEPARTMENT OF HEALTH:

Some Data on Reported Cases of Syphilis and Gonorrhea in Connecticut during 1939 — Henry P. Talbot, M.D., Hartford, Conn. 148

EDITORIALS:

A Public Health Program . . . 151

President's Plan for New Hospitals . . . 152

A Famous First . . . 153

The Greatest of All Gifts . . . 153

Our Younger Brother . . . 154

1940 Annual Meeting . . . 154

FROM THE SECRETARY'S OFFICE . . . 156

CONNECTICUT HOSPITAL ASSOCIATION . . . 159

SECTION ON ORTHOPEDIC SURGERY . . . 166

SECTION ON PROCTOLOGY . . . 166

GENERAL PRACTITIONER'S FORUM . . . 167

OUR NEIGHBORS . . . 168

NEWS FROM COUNTY ASSOCIATIONS . . . 169

LETTERS TO THE EDITOR:

Ragweed — A Pest . . . 171

Proposed Plan for Hospitals . . . 172

SPECIAL NOTICES: . . . 174

OBITUARIES:

George Waller Hawley, M. D. . . . Daniel C. Patterson, M.D. 176

Robert Milton Wolfe, M.D. . . . William J. Tracey, M.D. 177

John Joseph Cloonan, M.D. . . . Ralph W. Crane, M.D. 178

QUARTO NOTES (Book Reviews) . . . 179

Step Toward Perfection

Crude drugs and chemicals procured for the preparation of Lilly products must measure up to highest standards. Assays from outside sources, no matter how reliable, never are accepted without confirmation from the Lilly control laboratories.

Ephedrine Inhalants, Lilly—Ephedrine, topically applied to inflamed nasal mucous membrane, relieves congestion and facilitates drainage.

Inhalant Ephedrine Compound—contains ephedrine, camphor, menthol, and oil of thyme. INHALANT EPHEDRINE (PLAIN)—contains ephedrine combined with cinnamic aldehyde and benzaldehyde. EPHEDRINE JELLY—contains ephedrine sulfate with aromatics.

ELI LILLY AND COMPANY

INDIANAPOLIS, INDIANA, U. S. A.

The Connecticut State Medical Journal

Vol. IV. MARCH, 1940 No. 3

Acute Laryngotracheobronchitis

PAUL B. MACCREADY, M.D.,
New Haven, Conn.

Since the pandemic of influenza in 1918 many cases of acute laryngotracheobronchitis have been reported under various terms — fulminating laryngotracheobronchitis, acute septic tracheitis, non diphtheritic laryngotracheobronchitis, acute infectious laryngitis, etc., etc. For the most part the earlier reported cases were essentially of the fulminating type. More recently many milder cases have been reported as occurring in certain years. This year there have been about the ususal number of fulminating cases. However, there has been a tremendous increase in this vicinity in the number of milder cases, many of which were severe enough as to require hospitalization. For this reason it is essential for the general practitioner to familiarize himself with this condition.

Historical Note

Most of the reports of acute laryngotracheobronchitis have appeared since 1918. The condition was recognized before that time and a few scattered reports appeared. It was also recognized before then that the condition could occur during the course of measles. One of the earlier reports was by Lynch who reported 5 cases without fever and without the severe toxicity. This report was at great variance with those of most authors until the report by Smith in 1936. Smith reported 43 cases many of which were very mild, as occurring during 1933-34. The majority of earlier reports all emphasized the fulminating character of the disease.

In 1928 Baum reported a series of 24 cases, several of which occurred during measles. Baum recommended the use of intubation — a procedure discarded by most authors in favor of tracheotomy. Gittens in 1936 also reported a large series of 32 cases and emphasized the fulminating character of this condition. He also made the observation that the mechanical obstruction of the air passages of infants was more serious than the type of virulence of the infecting organism.

Richards in 1933 made the first extensive pathological study of this condition, illustrating his paper with excellent photographs. In 1938 he made a further publication of his pathological studies. Both reports were limited to studies on children. He summarized the cases reported by Baum, Gittens, Smith and his own 28 cases and found there was a mortality of 51%. He also stated that sulphanilamide was used in three of his cases with hemolytic streptococcus infection with but one recovery.

In 1936 Davis reported one case occurring in an adult—a report not given its true significance. Most recently Evans reported 3 cases in children, all of whom recovered Two of these cases due to a staphylococcus infection were treated with bacteriophage and apparently liquification of the secretions was accomplished.

In all, over 150 cases, severe enough to require hospitalization, have been reported since 1918.

Etiology and Pathology

As a separate clinical entity the picture is not entirely clear. Acute laryngotracheobronchitis occurs as sporadic cases during the course of influenza and occasionally during the course of measles. Apparently it represents a phase of upper respiratory infections which vary so tremendously from year to year. This year the cases differ in some minor respects from the cases previously seen. For a long time it was felt that the disease was the result of a streptococcus infection. This was because of the frequency with which the hemolytic streptococcus was obtained from post mortem cultures from the heart blood, even though other organisms were recovered from the trachea and bronchi. It is now recognized that this condition is an influenzal type of infection. What role the virus, which is supposed to cause influenza, plays is still under study. It is quite generally accepted, however, that the bacteria commonly found — the hemolytic streptococci, bacilli influenza, staphylococci and pneumococci, — are secondary invaders. The greater frequency in very young children among the sporadic cases can be explained on the basis of lesser immunity and anatomical factors.

The pathological changes are those of an acute descending inflammation of the upper respiratory tract. The mucous membrane of the larynx, trachea and bronchi is swollen and red and is covered by a thick, very tenacious blood stained exudate. The exudate peels off readily and leaves a velvety red surface. The exudate from the bronchioles is much more purulent in character.

Histologically the mucosa is destroyed over large areas. Many focal areas are devoid of all epithelial covering. The mucosa is replaced by exudate containing many red cells, fibrin, mucus and nuclear fragments. Ever more striking is the tremendous edema and congestion of the submucosa. The loose areolar tissue is spread widely apart. Distended blood vessels are very conspicuous and actual hemorrhage is one of the outstanding features. Cellular infiltration with polymorphonclear leucocytes is not pronounced in the earlier stages but soon occurs. The process is essentially a superficial one so that when repair occurs, contractures do not occur. In cases which get well, resolution is complete. It is the edema of the membrane, plus the nature of the exudate as just described, which accounts for the subglottic obstruction.

Similar changes occur in the smaller bronchioles but the changes are apt to be more extensive. Usually there is involvement of the adjacent alveoli producing what is clinically known as bronchiolitis. Where consolidation occurs, it is a very formidable sign and very few of these patients recover.

Judging from past experience when the influenza bacillus was recovered from the lungs or blood, the pathological picture was less marked than in cases where the hemolytic streptococcus was the organism. Where the staphylococcus was the organism found, and that has been the case where the condition has occurred in adults, the necrosis to be noted in the tissues of the trachea and bronchi was apt to be more pronounced. In view of what has occurred this year we may have to modify those observations. The more severe cases which we have seen in this section this year have resulted from infection with the influenza bacillus rather than the hemolytic streptococcus. Edema of the larynx has been pronounced in these cases. Possibly, we may find that the influenza bacillus is more apt to cause edema of the larynx while the hemolytic streptococcus is more apt to cause subglottic edema?

Symptoms, Diagnosis and Treatment

This condition occurs during the period of upper respiratory infections. Excluding the cases which occur during measles, there are always some signs of an infection of the upper respiratory tract, through it may be nothing more then a mild pharyngitis. There is nothing in the appearance of the throat or the symptoms which suggest a child may develop this condition. The child may go on for a variable period of time, a few hours to a few days, when he quite suddenly develops some difficulty in breathing in the nature of inspiratory stridor. In older children who are able to describe things, they say it feels as though there was something in the throat. In the present group of cases the condition has predominately begun with hoarseness or aphonia, suggesting a laryngitis. The inspiratory stridor has usually followed this within a matter of a few hours and has usually come on quite suddenly. This condition occurs as attacks, the patient quieting down some and breathing easier between attacks. These attacks gradually subside after 36 to 48 hours in the milder cases. There is practically always high fever, though not necessarily at the start, despite the cases reported by Lynch. The patient is definitely toxic and soon tends to become very restless, which indicates insufficient oxygen. There is very little question about the diagnosis at this stage. As most of these patients have been Schick tested there isn't much question about the diagnosis of diphtheria, even though the disease resembles diphtheria very closely. Of course, if there is any question of diphtheria, anti-diphtheritic treatment should be given immediately. The important thing, however, is that with the first development of symptoms, the child should immediately be put on steam inhalations. It is interesting to note that most of the cases in the past have occurred among the children of the moderately well-to-do. Apparently, our present day efficient heating systems dry out the air of the houses and it is felt that this is a definite factor in precipitating the condition. The steam inhalations should be continued constantly. The child should be kept in a small room where the whole room can be filled with steam. The child must be watched every minute of the time for the development of acute laryngeal edema. Relatively few of the patients who have been put on steam very early have developed this acute edema. In fact many of the patients can be cured by keeping them on steam for a matter of 3 or 4 days. It is still a question whether there is a difference between these milder cases which apparently can be cured and the acute fulminating cases. It is best to assume that one is merely an earlier phase of the other and treat them accordingly.

Later, definite inspiratory stridor becomes pronounced, bringing into play the accessory muscles of respiration. This latter feature is the one which usually sends the patient to the hospital, though the restlessness together with the toxemia and fever should be the symptoms which send the patient to the hospital. Diagnosis is usually made on the basis of these symptoms. The chest signs are those which result from obstruction. Instead of hearing rales which one would expect with a bronchitis or a bronchiolitis, the breath sounds are very distant. Laryngoscopy in many cases would show nothing, though it would help to eliminate the possibility of diphtheria. It should not be done unless one is prepared to do an immediate tracheotomy as it may precipitate an acute edema. Even the misuse of the tongue depressor may do this.

When the accessory muscles of respiration are called into play, a tracheotomy should be done, while the patient is in good condition and while it can be done without tremendous hurry. Though intubation may relieve certain cases it cannot be used universally. Besides, if it is necessary to do subsequent bronchoscopies they are infinitely easier through a tracheotomy opening. Considering the inflammatory changes in the mucous membrane of the trachea and bronchi, characterized by a thick sticky tenacious exudate which partially or completely occludes the upper air ways and which cannot be coughed out, repeated bronchoscopies are practically always necessary. We know that the cases this year belong to a milder category than what we saw in 1929-30 because it has not always been necessary to do a tracheotomy, even though the accessory muscles of respiration were working hard. Where the patients were under constant observation and it has been possible to watch them constantly, many have recovered without a tracheotomy.

Even though the tracheotomized patients are put in a steam tent and suction is frequently used, there is always the tendency for the secretions to dry and form crusts which cannot be expelled. The use of suction through the bronchoscope is often not strong enough to remove them and they have to be removed by forceps. In very young children it is not possible to reach the smaller bronchi at all adequately. Obstruction occurs more readily. From an anatomical point of view the younger the child the more grave is the outcome All sorts of measures have been used to aid in liquifying these bronchial secretions but to no real avail. One would not expect any medication to help if one considers the underlying pathology, though recently Evans reported some success with the use of bacteriophage in two cases with staphylococcus infection.

Of almost equal importance to the respiratory distress is the severe toxemia. Most of the children suffer with bronchiolitis. If consolidation occurs the toxemia becomes so marked that relatively few cases have ever recovered. The toxemia must be combated by supportative measures — transfusions, glucose, infusions and fluids in large amounts. Sulfanilamide used in some streptococcus cases has not given good results. Sulfapyridine apparently is preferable in cases due to the influenza bacillus. Neither has given the striking results they do in other sorts of infection.

Resumé

Acute laryngotracheobronchitis is an acute infection of the upper respiratory tract which occurs sporadically during the course of influenza. It varies from year to year depending on the prevalence of the so-called secondary invaders. While it can occur in adults it occurs predominately in children, due to lesser immunity, and especially in very young children where anatomical factors play a role. It is characterized by high fever, toxemia and an intense imflammatory change in the mucous membrane and walls of the larynx, trachea, bronchi and usually the bronchioles. These changes tend to produce obstruction to respiration and at any moment death may result from acute edema of the larynx or more commonly from subglottic edema. While treatment has become clarified no startling advances have been made and a successful recovery is still to be looked on as an accident rather than the result of excellent care. The only rival advance which seems to have been made is that when these children are put on constant steam inhalations very early, it may aid in preventing the more fulminating phase of the disease. Even this cannot be accurately concluded from this year's experience, since we are dealing with a condition which, while much more prevalent this year, is not as severe as has occurred in the past.

BIBLIOGRAPHY

Baum, H. L.: Acute Laryngotracheitis in Children. Jour. A. M. A., 91: 1097 (Oct. 13) 1928.

Barry, G.: Case report: Membranous Laryngitis and Tracheitis with Staphylococcus Aureus Hemolyticus Infection Ann. Otol., Rhin. and Laryng. 37: 960 (Sept.) 1928.

Bradford, W. L., and Leahy, A.D.: Acute Obstructive Laryngitis: Clinical and Bacteriologic Study in Sixty-Six Cases. Am. J. Dis. Child. 40: 298 (Aug.) 1930.

Bugg, C. R.: Acute Laryngeal Obstruction in Children South M. J. 24: 1057 (Dec.) 1931.

Codd, A. N.: Obstructive Laryngeal Dyspnea, Ann. Otol., Rhin. and Laryng. 40: 242 (March) 1931.

Daily, L., and Allen, N. A.: Unusual Case of Acute Infection of Epiglottis and Larynx: Tracheotomy and Recovery. Laryngoscope 36: 367 (May) 1926.

Davis, D.: Acute Fulminating Laryngotracheobronchitis in an Adult. Arch. Otolaryng. 23: 686 (June) 1936.

Evans, M. G.: Acute Laryngotracheobronchitis: Report of Three Recovered Cases. Ann. Otol., Rhin. and Laryng. 48: 216 (March) 1939.

Gardener, L. U.: Three Cases of Infection of the Upper Respiratory Tract with Staphlococcus Pyogenes Aureus. Am. J. M. Sc., 155: 380 (March) 1918.

Gittens, T. R.: Laryngitis and Tracheobronchitis: Reference to Non-diphtheritic Infections. Ann. Otol., Rhin. and Laryng. 45: 1165 (Dec.) 1936.

Hart, V. K.: Streptococci Laryngitis; Report of Case with Very Rare Complication. Ann. Otol., Rhin. and Laryng. 36: 761 (Sept.) 1927.

Husik, D. H.: Acute Laryngeal Edema. Laryngoscope 36: 352 (May) 1926.

Hyde, C. I., and Ruchman, J.: Acute Infectious Edematous Laryngitis in which Recovery Followed Tracheotomy. Arch. Pediat. 48: 124 (Feb.) 1931.

Jackson, C. and C. L.: Acute Laryngotracheobronchitis. Jour. A. M. A. 107: 929 (Sept. 19) 1936.

Johnson, M. C., Acute Laryngotracheobronchitis in Infants: Report of Three Cases. Arch. Otolaryng. 17: 230 (Feb.) 1933.

Leigh, H.: Sudden Death from Acute Laryngeal Obstruction of Non Diphtheritic Origin: Reports of Cases Occurring During Winter Epidemic and Autopsy Findings. Southwest, Med. 11: 210 (May) 1927.

Lynch.: "Pot Pourri." Laryngoscope 34: 753 (Oct.) 1924.

Mainzer, F. S.: Acute Laryngotracheobronchitis. Pennsylvania M. J. 33: 24 (Oct.) 1929.

Morris, M. E. Jr.: Laryngeal Stenosis as a Complication of Measles. New York M. J. 106: 1125 (Dec. 15) 1917.

Richards, L.: Acute Laryngotracheobronchitis. Ann. Otol. Rhin. and Laryng. 42: 1014 (Dec.) 1933. (Ibid). A Further Study of the Pathology of Acute Laryngotracheobronchitis in Children. Trans. Am. Laryng. Rhinol. And Otol. Soc. 372, 1938.

Seitz, R. P.: Acute Streptococcic Laryngitis in Children: Report of Cases. California and West. Med. 30: 259 (April)1929.

Simpson, W. L.: Pneumothorax Complicating Tracheotomy in Fulminating Laryngotracheobronchitis. Arch. Otolaryng., 26: 411 (Oct.) 1937.

Smith, W. J.: Acute Laryngotracheobronchitis in Children. Arch. Otolaryng. 23: 420 (April) 1936.

Smith, E. D.: Tracheotomy for Edema of the Larynx Complicating Influenza. Kentucky M. J. 17: 282 (July) 1919.

Smith, H.: Fulminating Septic Infection of Pharynx and Larynx. Ann. Otol., Rhin. and Laryng. 33: 1339 (Dec.) 1924.

Thomson, H.: Fulminating Septic Infection of Pharynx and Larynx. Ann. Otol., Rhin. and Laryng. 33: 1339 (Dec.) 1924.

Thomson, C. A.: Acute Stenotic Laryngitis Simulating Laryngeal Diphtheria, J. A. M. A. 78: 1456 (May 13) 1922.

Tuley, H. E.: Fatal Laryngeal Edema Following Influenza. Kentucky M. J. 17: 315 (Aug.) 1919.

Winternitz, M. C., I. M., and McNamara, F. T. The Pathology of Influenza. Yale Univ. Press, New Haven, 1920.

A Psychiatric Approach to Problems in General Medicine*†

JAMES H. WALL, M.D.,
White Plains, N. Y.

In medical education today, increased emphasis is being placed upon the teaching of psychiatry. The early recognition and proper treatment of the more serious mental reactions are stressed. Of more practical significance to the man preparing for general practice or the nonpsychiatric specialties is the acquisition of the psychiatric point of view in the treatment of all patients. This includes an intelligent and sympathetic understanding of the individual as a whole, his personality, his background, the social and economic forces involved, as well as a grasp of the complaint presented, whether it be an actual physical disease or a manifestation of emotional difficulties. It is an approach as old as the first wise physicians. Down through the ages the true physicians have had this broader view of the problem and an innate ability to handle it. Certainly the position of the old family doctor afforded an excellent opportunity for the development of this point of view. Even under such favorable circumstances, this ability was not a part of every physician's equipment. In our present day psychiatric teaching we attempt to formulate the psychiatric approach in such a way that it may become an additional tool of every medical man. Students on the wards of general hospitals and in out-patient departments are taught a definite method of examination and of eliciting information from the patient and his relatives. Patients with organic disease often present emotional problems and the presence of one does not necessarily preclude the presence of the other. The anxiety associated with physical disease is incapacitating and oftentimes aggravates the existing pathology. Effective treatment demands that we turn attention to the personality. It is the purpose of this paper to discuss some manifestations of emotional difficulties in general somatic systems, in an effort to show how a psychiatric approach can solve some of the problems confronting the man in general medicine.

In turning our attention to the cardiovascular system we readily see how our language portrays the intimate association of the heart and the emotions. We call a person light-hearted or down-hearted; we say that the heart of a person in love has been pierced by Cupid's dart. In all instances we are referring to a state of feeling. It is not surprising that serious emotional difficulties are expressed by many patients in symptoms referable to the heart. A careful history and physical examination may be negative, and even after reassurance, the palpitation and discomfort may continue. Here the psychiatric technique must be brought into play. If the family history notes a relative with heart disease, we must investigate the patient's contact and associations with that relative. We must discover the dynamic effect of the relative's suffering or death on the patient's developing attitudes toward health and sickness. What has the patient learned from other physicians about his condition? What are the patient's own peculiar anatomical and physiological misconceptions of the heart? What are the patient's tendencies or reaction patterns? Does he work under too much tension and are there unfaced or poorly managed hostile attitudes toward wife, parent, or superior? Does the psychosexual development and present adjustment show a wide variation from the average? Some of these points may best be illustrated by the presentation of the following case history:

A married man of 38 was admitted to the hospital seven years ago. For two years he had complained of pain in the left side of his chest, palpitation, and feelings of numbness in his left arm and left leg. He feared that he would die suddenly of angina pectoris. He had been seen by many physicians who found no physical basis for the complaints. From one to the other he passed, receiving words of reassurance until a week before his admission

---

*From the Department of Psychiatry, Cornell Medical College and the Clinical Service of the New York Hospital-Westchester Division.
†Read at the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

when he was seen by a physician who advised him to enter a mental hospital for psychiatric treatment.

The family history showed that his father had died suddenly of a stroke and that his mother to whom he had been devoted, died suddenly of heart disease at 59, six years prior to the patient's admission. He was the fourth of five children. His early development was normal. He was a serious child who was inclined to be religious. His school record was excellent and upon completing high school at 19, he became a salesman.

An inquiry into his psychosexual development showed that he masturbated a great deal during adolescence, with more than usual feelings of guilt. There were also symptoms of heart burn and visceral tensions which he looked upon as punishments for his sexual indulgences. At 20 he began to have intercourse with prostitutes and at 31 married a woman with whom he had been intimate and upon whom he had had an abortion performed. His marital adjustment was far from happy, he did not wish children and after marriage had other abortions performed. He was able to support children, but he feared that they would be too much trouble. During this time he was aware of anxiety but he worked well. He was 32 when his mother died suddenly of heart disease. Thereupon he became more anxious and religious, began to lose satisfaction in his work and to become preoccupied with right and wrong and fear of punishment. Four years later, that is two years prior to admission, after suddenly leaving a position, he complained of anxiety, palpitation, a choking sensation, shifting pain and tension in the upper abdomen and chest, together with numbness of his left extremities. Then began his round of physicians, in the midst of which he told his story to a young physician who was a close relative. The relative, in his inexperience, informed the patient that he had angina pectoris and that he would "go out like a light." He seized upon this impressive, but casual and cruel diagnosis, remained at home as an invalid except for frequent visits to various physicians, and sent his wife out to make the living. He lost weight, became impotent, and assumed a nagging, petulant attitude toward his wife when she returned from work. On admission to the hospital he was found to be in good physical condition including all laboratory studies. He walked about, pressing his hands to his chest, complaining of pain and fear of sudden death. He slept and ate well, and from the first, when all the physical findings were seen to be negative, he was urged to follow a full schedule of occupational therapy and other hospital activities. To be able to endure the greatly increased exertions was substantially reassuring to him. At first he resented a psychiatric approach but gradually he reviewed his development as we have presented it. He came to understand the relationship between the symptoms of heart burn and masturbatory conflict and guilt in adolescence. He saw through the sickly impractical nature of his religiosity. He appreciated his fears of assuming adult responsibility and the complicated guilt reaction to having his wife aborted. Of great importance was his understanding of the dynamic influence of his mother's death of heart disease. He had identified himself with her, had become less interested in work, more religious and hypochondriacal and eventually he had exchanged rôles with his wife, who went out to work while he stayed at home for two years. It was with some difficulty that the patient fully reviewed his life and learned better ways of managing, but he fully recovered and after several months in the hospital he has been gainfully employed for six years.

We are familiar with the work that has been done in this clinic* on the relationship between temperament and such conditions as peptic ulcer and colitis. These studies go beyond the mere statement or acceptance of the role of temperament, and they suggest a definite method of approach, with emphasis on etiology and possible prevention. Today we are beginning to see more of these people before more serious organic conditions develop and before unnecessary surgical intervention, in some instances, has fixed the patient's attention and justified his desire for a physical explanation of his troubles. Intensive medication and surgical operations in patients whose gastrointestinal symptoms are on an emotional basis, have the effect of confirming the patient in this unhealthy way of solving his problem. The anxiety associated with the symptom is allayed and at the time of the operation and shortly thereafter the attention is focused on the dramatic crises and procedure. Invariably the story is that the patient has improved temporarily and has been comfortable for a time but the underlying causes of the emotional difficulties have been left untouched.[3] It is not surprising in such cases to find a recurrence of symptoms and an increased conviction on the part of the patient that a real physical cause is yet to be uncovered; — hence, the continued round of physicians and clinics. The earlier the emotional factors are recognized and dealt with, the better the outlook. The following illustrative case histories of two patients demonstrate this point:

A single woman of 30 was admitted to the hospital with complaints of abdominal discomfort, nausea, and vomiting. For five years these symptoms had persisted despite four surgical operations.

She came of a closely knit family of unstable people. She was the second of five children, and her birth and early development were normal. She did well in school and entered upon a successsful business career after finishing college at 21. The symptoms of nausea and vomiting came to the attention of her relatives five years before her admission, when she was 25. She was seen by many physicians and was in many hospitals but no positive physical findings were ever elicited. She continued her work, but she persuaded someone to do a laparotomy two years before her admission, when she was 28. At that time a normal appendix was removed. For two weeks after the operation she was comfortable but the symptoms recurred the day she left the hospital. Three months later an operation was done for adhesions. Everything went well for two weeks but again the symptoms returned and her complaint of pain was such that she was given opiates. After another month there was a third laparotomy at which time the gall bladder was drained. After the repetition of the same series of events, the gall bladder was removed at the time of her fourth and last laparotomy. During the next year prior to her admission to a mental hospital her symptoms continued and she took opiates and barbiturates to relieve her discomfort. By the time of her admission she weighed less than 80 lbs. Her physical examination, including laboratory and x-ray studies, was essentially negative. She was tense, talkative, and critical of all doctors and nurses. Although she continued to vomit for the first few weeks, she was urged to eat and rapidly gained weight. She was on an active schedule of hospital activities. In the beginning her symptoms were aggravated by a discussion of her emotional problems. The close associations with relatives who had gained much attention through complaining had an important influence on her own personality development. She had been disgusted with menstruation as a girl and she recalled that during her first few menstrual periods she was nauseated and vomited, but these symptoms passed. Her school and business career absored her attention up to the time of the beginning of the symptoms at 25. After several weeks in the hospital she reluctantly told of a clandestine love affair which began at 25 shortly before the onset of the symptoms of gastric tension and pain, nausea and vomiting. The affair was with a man who for many reasons could not marry her. She suffered intense feelings of guilt and the conflict was associated with much anxiety before the symptoms set in. Needless to say the psychotherapy was not successful. She saw that she was in an unhappy predicament but this could not explain her symptoms entirely. After all, she had been operated upon four times and her complaints had been so severe that opiates had been prescribed. After hospitalization which resulted in temporary improvement, she resumed her life, with no modifications, and when her difficulties recurred she evaded psychiatric help.

---

*The Departments of Psychiatry and Mental Hygiene and Medicine of the Yale University School of Medicine and the Psychiatric and Medical Services of the New Haven Hospital.

By way of contrast I should like to present the following patient, a married woman of 34. Her complaints were pain under the heart, nausea, gaseous eructations, and vomiting. She came of stable stock and was the fifth of eight children. Her birth and early development were normal. Her menses commenced at 13, and her physical health was generally good. Upon finishing college at 21 she became a teacher, in which profession she continued successfully until the age of 25 when she was married to a man ten years her senior. Her two children, a boy of 6, and a girl of 3, were born when the patient was 28 and 31 respectively. Her trouble began after the birth of her daughter, the second child. She was depressed and anxious and for a few months began to complain of pain under her heart which was relieved by belching and vomiting. She also had fainting spells. Repeated and exhaustive studies were negative. At the request of her family physician she was observed by a psychiatrist one year before admission when she was in a general hospital. Psychiatric treatment was recommended but not followed. A year later in the same general hospital her family physician held out against an exploratory operation which was recommended by two other medical men and finally persuaded her husband to arrange for her admission to a mental hospital.

At the time of admission she was undernourished, but otherwise the physical findings were negative. She was most dramatic in her play for attention, fainting during the time a physician was on her hall, vomiting after most meals, and demanding much attention from those around her. She was carefully supervised after meals and was immediately placed on a full schedule of activities. As she gained weight, she became anxious and began to unburden. As a child she had been jealous of her three younger siblings. She remembered that she had cried for attention when she saw them in her mother's arms. She had sucked her thumb until the age of 6, and at an early age showed a great deal of curiosity about sexual matters. As a young girl she had believed that kissing caused pregnancy and that babies were born by rectum. She appeared shy and prudish, and was most conscientious in her work. She had adjusted well to married life until the birth of her second child, a girl. She then became jealous when her husband paid attention to the daughter. She noticed that her fainting and complaints of fatigue brought forth the concern of her most indulgent husband. With the beginning of the symptoms of nausea and vomiting she remembered how pleased she had been with the concern of her husband and his search with her for help. With an understanding of some of the motivation of her symptoms she began to show a very marked improvement. She increased her range of interests while in the hospital and after six months' residence she returned to the community. She has done well for eight years.

In turning to gynecological problems, we come to an understandable correlation between the psychological and physical. We are familiar with the persistence of pelvic symptoms after various types of physical treatments. No one can criticize the sound wisdom of careful examination and the institution of necessary corrective measures, but one must remember that in this sphere of our work the emotions play a dominant role. In dealing with persistent symptoms of vaginismus, frigidity and dyspareunia, we must take into consideration the psychological and emotional conflicts and not be content with physical measures alone. An investigation of such patients' personalities may reveal excessive guilt over masturbation, a feeling that the habit has done irreparable harm, and that failure to achieve satisfactory sexual adjustment is a punishment. Oftentimes these symptoms are associated with or may be the expression of rejection of femininity and hatred of men. In a recent study of fifty women patients who were addicted to alcohol, we found that forty of them suffered from dysmenorrhea. Most of them had had previous physical treatments and glandular therapy, but the symptoms had persisted. Our gynecological consultant found no pathology, but a psychological investigation revealed a repudiation of their femininity. Menstruation had been disgusting to them; the phenomenon was interrupted as an insult and injury to a self-centered or narcissistic type of personality. Their dreams depicted the same attitude.[4] The psychic representation of the generative organs, together with emotionally toned misconceptions and strivings in the development of the individual, have a psychological structure more complicated than anatomy.

We are familiar with the physiological manifestations of the nemopause, but the psychological forces at work are worthy of our attention. The fear of outgrowing one's need and usefulness is an important factor. With the general aging may come too great emphasis on loss of charm and beauty with associated feelings of neglect and jealousy. Increased erotic drives may bewilder and cause embarrassment. Worries over finances may be indicative of the general insecurity. An investigation of such personality factors should accompany the regular physical examination at this life period. A sympathetic listener and teacher who shows the woman in a simple way what is going on, is as helpful as the sedatives and endocrine preparations prescribed. Recently I saw a married woman of 49 with the unpleasant physical sensations of the menopause. After a careful physical study her family physician had called for psychiatric help. She was extremely irritated by her healthy adolescent daughter. She noticed that all of her symptoms were more bearable when the young daughter was in school and that her restfulness increased when the daughter and the younger set were in her home. After a few interviews, it was a surprise to the patient, who was an attractive woman, to learn that she was envious of her young daughter who was entering the stage on which the curtain was descending for herself. The understanding of this situation did much for the peace of the home, the daughter's health, and the menopausal symptoms of the patient.

In closing, I should like to say that there is no royal road by which one may acquire the psychiatric approach to human problems as seen by the man in general medicine. We are attempting to formulate methods of study and treatment which must be practised to be learned and to become a part of our armamentarium.

BIBLIOGRAPHY

1. Strecker, E. A. and Ebaugh, F. G., Clinical Psychiatry, P. Blakeston's Son & Co. Inc., Philadelphia, Pa. 1935.

2. Dunbar, H. Flanders, Emotions and Bodily Changes. Columbia University Press, New York, N.Y. 1935.

3. Greenacre, Phyllis, Surgical Addiction, A Case Illustration, Psychosomatic Medicine, April, 1939.

4. Wall, James H., A Study of Alcoholism in Women, American Journal of Psychiatry, January, 1937.

⁂

THE RIGHT SORT OF MEDICAL SERVICE.

We must unshackle the individual and permit him to move forward to meet his necessity, because it is by the stimulus of necessity that civilization advances. Eliminate all the licensing systems not definitely necessary for the protection of society. Remove all unnecessary controls and restore government to its rightful principal functions of police duty.

Let us beware lest, in our desire to be kind to the weaker brethren of today, we are more than unkind to the brethren of tomorrow.

The right sort of medical service can best be assured to all by keeping the mastery of our own dollars. The future of public health must center around the family physician who with his bag and office equipment still cares for ninety-two per cent of the nation's illness.

The treatment of illness must remain a profession. Now, what constitutes a profession? Personal service! It cannot be standardized. There is an intellectual character to this service, with considerable self-direction and individual responsibility. There can be but one master in the house of medicine and that is the doctor himself.

Jour. Tenn. State Med. Assoc., Sept. 1939

Modern Methods in the Treatment of Pneumonia*

CHESTER S. KEEFER, M.D.,
Boston, Mass.**

1. Pathogenesis of Pneumonia

In the pathogenesis of pneumonia 95 per cent of all cases of lobar pneumonia are caused by one of the thirty-two specific types of pneumococci and that at least 90 per cent of all cases of pneumococcus pneumonia in adults are caused by Types I, II, III, V, VII, and VIII. Most of the cases of lobar pneumonia are observed between the ages of 20 and 50 years and many cases are preceded by upper respiratory infections, excessive exposure to cold, or excessive use of alcohol, or follow anesthesia. Contact infections are most likely to be observed in families or under conditions of overcrowding.

2. Factors Influencing Prognosis

In assessing the value of any therapeutic agent, it is necessary to be familiar with the various factors influencing prognosis. In pneumonia there are so many variable factors that it is frequently difficult to decide which ones are the most significant. However, from a study of many cases, it is quite clear that four factors, more than any others, influence the outcome of pneumonia.

They are

1. Age
2. Bacteremia
3. Type of Pneumococcus
4. Form of Treatment

Other significant factors are:

5. Race and Type of Work
6. Number of Lobes Involved
7. Leucocyte Count
8. Focal Infection
9. Debilitating Disease
10. Pregnancy
11 Alcoholism
12 Miscellaneous Features
    (a) Degree of Cyanosis
    (b) Delirium
    (c) Abdominal Distention
    (d) Jaundice
    (e) Pulmonary Edema

Age: By common consent, it is recognized that the greatest number of deaths from pneumococcic pneumonia occur over the age of 40 years, and the fatality rate increases with age. The lowest death rate is observed between the ages of 2 and 11 years, but from then on it increases from about 8 to 85 per cent from the ages of 12 to over 70 years. The reasons for the increase in death rate with advancing age are numerous and not completely understood, but the higher incidence of bacteremia and the presence of debilitating diseases are very significant.

Bacteremia. The important points to remember about bacteremia in pneumonia are as follows:

It increases in frequency with advancing age, so that it is about three times as frequent over the age of 40 as under 40.

It is always of serious importance regardless of the day of the illness on which it is detected, since the fatality rate is three to four times as high in bacteremic patients as it is in those without bacteremia.

While it is always of serious prognostic importance, regardless of age, more patients recover with bacteremia under 40 than over 40 years of age.

It is found most often in patients with Types II, V, and I (20 to 40 per cent) and less often in Types III, VII, and VIII. The highest fatality rates with bacteremia are encountered in Types III, VII, V, I, II, and VIII, respectively.

It is encountered more often when there are multiple lobes involved, leucopenia, severe abdominal distention, deep cyanosis, delirium, and pulmonary edema, than it is without these features.

At the Boston City Hospital the incidence of bacteremia is approximately 36 per cent of all cases. In other large series of cases it is lower (17 to 20 per cent). This must be taken into account in assessing fatality statistics from various clinics.

The fatality rate in bacteremic cases varies

---

*Summary of a paper presented before the Hartford Medical Society, December 4, 1939.
**Professor of Medicine, Boston University School of Medicine, and Director, Evans Memorial Hospital, Boston, Mass.

from 25 to 100 per cent, depending upon age, and from 50 to 98 per cent, depending upon type.

Bacteremia is always more serious when accompanying broncho-pneumonia than it is in lobar pneumonia.

The incidence of bacteremia is higher in patients with preexisting systemic diseases.

Bacteremia is at least twice as frequent in patients who develop postpneumonic focal complications as it is in a nonbacteremic group.

Bacteremia is less frequent in patients who are treated with serum than in those who do not receive serum treatment.

In general, it can be said that, of the bacteremic patients recovering without treatment, the number of colonies of pneumococci in the blood is less than 10 per cubic centimeter. If the number of colonies increases in successive blood cultures, or if the blood culture is positive more than once, the prognosis is worse than if there is a single positive blood culture with a small number of organisms.

While the fatality rate increases with advancing age in the nonbacteremic cases as well as the bacteremic cases, it rises much more abruptly after the age of 50 years. Under 50 years, it is approximately 15 per cent; over 50 years it is about 55 per cent.

In brief, one can say from the experience with large numbers of cases of pneumonia that regardless of the treatment employed, the lowest fatality rates will be found in patients without bacteremia, and especially in individuals without bacteremia who are under forty years of age.

Type of Pneumococcus. The type of infecting pneumococcus has long been regarded as important in affecting the outcome of the disease, and its significance can not be ignored. Part of the variations in the severity of the disease produced by different types of pneumococci would seem to be dependent upon the age at which the patient is infected with a particular type of pneumococcus, and the variation in the capacity of the organism to invade the circulating blood. Of the common types, the fatality rate is highest in order of frequency in Types III, II, V, I, VIII, and VII. This corresponds roughly with the bacteremic incidence with all types excepting Type III. It has been maintained that one of the reasons why Type III is so serious a disease is that it occurs predominately in elderly people. This is true in part but, from the experience of Finland and Sutliff, the fatality rate in Type III pneumonia has always been higher than with any other type, regardless of the age of the patient and the incidence of bacteremia. The next most serious type is Type II, since it is accompanied by a high fatality rate, especially in patients over 40 years of age.

In summary, then, it can be said that the type of infecting pneumococcus is significant in prognosis, in particular Types II, V, and III, and this is so even when the incidence of bacteremia and age are considered.

Number of Lobes. The number of lobes involved indicate the severity and extent of the infections, so that the fatality rate rises with the increase in the number of lobes involved.

Pregnancy. Pneumonia occurring in the pregnant woman has about twice the fatality rate of the same disease in the nonpregnant woman.

Leucocyte Count. The leucocyte count in itself may not be of aid in prognosis; but, speaking broadly, it can be said that patients with leucopenia have a higher fatality rate than individuals with a moderate leucocytosis.

Alcoholism. Individuals who use large amounts of alcohol have a higher risk rate than those using moderate amounts, or the teetotalers. On this point there is general agreement.

Race and Type of Work. These two factors are operative and are especially significant in the case of the colored race and of the person whose occupation is that of heavy manual labor. That is to say, the colored man and the laborer have a poorer chance of recovery than the white individual who is not a laboring person.

Focal and Mixed Infections. Individuals with focal infections, such as empyema, and infections due to more than one type of pneumococcus or another organism have a higher fatality rate than those with a single infection or without a complicating focal infection.

Debilitating Diseases. When patients with cardiovascular, renal, or hepatic disease develop pneumonia, it is always a serious matter. In such cases, it has been demonstrated that the fatality rate is always higher regardless of age.

To sum up, then, it is evident that the following factors may be considered unfavorable in assessing prognosis in pneumonia: age over 40 years, bacteremia, infection with Types II, V, or

III, involvement of multiple lobes, type of work, overindulgence in alcohol, cardiovascular disease, and the presence of focal infections. The more "untoward" factors that are present, the more serious the disease and the poorer the outlook. To repeat, then, the most important are the age and the incidence of bacteremia.

3. Treatment of Pneumonia

There are two important therapeutic agents available for the treatment of pneumonia — serum and sulfapyridine. Inasmuch as it may be desirable to treat some patients with both agents, it is well to review some of the facts concerning the value of these agents.

Serum Treatment. As more and more experience has accumulated over the past twenty-five years, we are now in a position to say something about the treatment of some types of pneumonia with specific sera. This is especially true of Type I, but information is now available for a statement concerning Types II, V, VII, and VIII, as well.

The following statements concerning the value of Type I antipneumococcic serum are justified. It reduces the fatality rate, shortens the course of the disease, prevents a spread of the infection, and greatly reduces the incidence of empyema and other focal infections. In order to obtain the best results it is necessary to treat the patients early, that is, before the fourth day of the disease; and to use large amounts of potent serum which will produce either no reaction or, at best, only minimal thermal reactions. When patients are treated with specific serum after the fourth day of the illness, or with serums of low potency, then the results will be poorer, especially when the serum causes reactions and is not given in adequate amounts.

The most striking results are obtained in patients under 40 years of age, without bacteremia and with only a single lobe involved, who are treated before the fourth day of their illness. The fatality rate can be reduced at least 66 per cent in all nonbacteremic cases, and at least 50 per cent of the bacteremic cases with the proper use of serum. In certain groups of cases the fatality rate can be reduced to between 1 and 3 per cent with the use of Type I serum.

In Type II cases, the results of serum treatment have varied in different clinics, and from one year to another. This has been found to be due to the use of varying amounts of serum and to the lack of serum of uniformly high potency. Moreover, it is known that the fatality rate of Type II infections is often very high, and that this organism tends to invade the blood much more often than do other types of pneumococci. Within recent years it has been possible, by using potent rabbit and horse serums in large amounts, to reduce that fatality rate in patients with Type II pneumonia. Here again, the best results are obtained in nonbacteremic patients under 40 years of age, with a single lobe, who are treated before the fourth day of their illness. Less striking results are obtained in patients over 40 years of age, especially when there is bacteremia.

What has been said for Types I and II also applies to Types V, VII, and VIII. The results of serum treatment of other types are too limited to say just what their effect will be in the future, although the results so far indicate that they can be influenced in a favorable sense.

Sulfapyridine Treatment. From information which has accumulated so far, it is fair to say that sulfapyridine will reduce the fatality rate of pneumonia. It is most effective in children and young adults without bacteremia who are treated early in the course of the disease. It shortens the course of the disease and decreases the number of cases of empyema. There is accumulating evidence that in adults, at least, the best results are obtained when sulfapyridine is used along with serum therapy.

At present the following tentative rules may be adopted in the treatment of pneumonia.

1 All patients with pneumonia should have:
   (a) Sputum culture and typing
   (b) Blood culture taken before any treatment is started
   (c) Total leucocyte count
   (d) Examination of the urine

Sulfapyridine should be given alone as soon as the diagnosis is established unless there is
   (a) Granulocytopenia, severe anemia, or jaundice
   (b) Signs of chronic nephritis

It is probably unwise to give it to patients with post-operative pneumonia, especially if there is the possibility of vomiting doing harm.

Finally, if an individual has received sulfapyridine previously and is known to have developed a drug rash, leucopenia, anemia, or jaundice, it would be inadvisable to give the drug again.

Serum and Sulfapyridine Treatment. Serum and sulfapyridine should be given under the following circumstances.

1 When sulfapyridine alone in the usual doses has failed to cause improvement within 18 to 24 hours.
2 In patients over 40 years of age.
3 In pneumonia complicating pregnancy.
4 When more than one lobe is involved.
5 When bacteremia is known to be present.
6 In all severe cases of Type III pneumococcus infections.
7 When sulfapyridine is accompanied by severe nausea and vomiting or other toxic effects.

Toxic Manifestations of Sulfapyridine

1 Nausea and Vomiting
2 Anemia
    (a) Acute hemolytic type
    (b) Milder delayed type
3 Leucopenia, Agranulocytosis
4 Renal Complications
    (a) Hematuria
    (b) Colic
    (c) Nitrogen or water retention
    (d) Renal calculi
5 Mental Symptoms—Depression or Excitement
6 Liver Damage — Jaundice
7 Drug Fever
8 Drug Rash
9 Cyanosis

* * *

FROM KENTUCKY

Twenty nine counties in the State of Kentucky in 1938 had a per family income less than $500. Approximately 10% of the State's population were living on relief funds. Seventy-five per cent of the population of the State is served by 54% of the physicians. In the urban communities there are 14.7 physicians for each 10,000 population; in the rural area 5.8 per 1000 population. Fifty counties in the State have 72 general hospitals. These hospitals have a total bed capacity of 4,570. Twenty-three of the 72 general hospitals, with 65% of the total beds, are in 13 cities. In only 7 counties of the State are there no midwives. In the southeastern section of the State there are 25 counties in which 40% or more of the deliveries are by midwives. Eight counties have no registered nurses and twenty counties have one nurse each. In thirteen of these the only nurse is the public health nurse who is part of the county health department. Maternal mortality has decreased only 2.5 per 1,000 live births in 27 years and practically all of this decrease has been since 1932. The infant mortality rate has decreased from 87 deaths per 1,000 live births in 1917 to 63.2 in 1938. Hospital facilities for the care of tuberculous patients are wholly or woefully inadequate.

Bull. Ky. Dept. Health, Aug. 1939

* * *

LEAD-FREE PAINTED TOYS FOR CHILDREN

A campaign to prevent lead poisoning among children, caused by the use of lead paints on toys and cribs, has been undertaken by the Pennsylvania Department of Labor and Industry as an outgrowth of its program for occupational disease prevention.

Safe practice in the manufacture of painted toys is described in Lead-Free Painted Toys (Safe Practice Bulletin No. 14, Department of Labor and Industry, Harrisburg, Pa., 1939, 10pp. mimeographed). A test is given by which the presence of 0.1 per cent of lead in paint can be detected.

It is pointed out, however, that there is need for an investigation by the medical profession to determine a standard for lead content in paint used on toys, children's furniture, and so forth, that will adequately protect the health of the child.

The Child, Oct. 1939

The PROFESSIONAL EQUIPMENT Co. | EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS | TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

The Treatment of Pneumonia*

LOUIS H. NAHUM, M.D.,
New Haven, Conn.

Progress in Pneumonia Mortality

In the last two years we have witnessed a striking decline in pneumonia mortality in all age groups. With the introduction and wide use of anti-pneumococcus serum in 1938, the mortality of cases treated with serum declined over 50% from the accepted 25 to 30% which formerly prevailed. The introduction of Sulphanilamide led to a further decline in mortality since the drug is known to exercise some chemotherapeutic effect even in pneumococcus infections and especially Type III. This year, however, the generalized use of Sulphapyridine has dramatically changed our whole attitude towards pneumococcus infection in general, so that from a mortality of 25 to 30% of untreated pneumonia patients we may expect no more than 4 to 8% in treated cases.

Many reports on well-controlled series of treated and untreated patients are now published, in all of which there is uniformity as regards the striking decline in mortality. Lord, in the N. E. Journal of Medicine, Oct.12, 1933 has summarized 1612 treated patients from the literature, of whom only 6 to 7% died, as against an expected mortality of 30%. The reports in infants and children are even more remarkable, both Barnett and Hodes reporting large series of cases treated with the drug without a death.

Unfavorable Factors in Pneumonia

Since there are even now 4 to 8 out of a hundred patients with pneumonia who succumb in spite of present methods of therapy, it is obvious we have not yet reached the ideal in the management of this disease. It is therefore useful to recognize the factors which affect the course of pneumonia unfavorably. Lord points out that in patients 50 years of age and over, the mortality of treated cases was 20% as against 2% for those under 49. Since the mode of treatment with Sulphapyridine in each group was similar, the higher mortality must be attributed to the inability of many of these patients to develop natural resistance to the invading organism. Perhaps aside from age alone, the greater known incidence of constitutional diseases, such as hypertension, arteriosclerosis, diabetes, chronic lung, heart and kidney disease, in patients over 50 is responsible for the unfavorable course of pneumonia in this age group.

Another unfavorable factor is bacteremia. Until the last two years patients exhibiting a positive blood culture with several organisms per c.c. of blood, showed a very high mortality in pneumonia; in fact, over 80%. Even since the introduction of Sulphapyridine the mortality in such patients is still almost 20%. It is therefore apparent that when organisms invade the blood stream in any numbers, it is a sign of the existence of very poor defenses in the patient.

When a patient exhibits rapid spread to both lungs or shows signs of great toxicity, such as high fever, delirium, rapid pulse, tympanitis, it must also be inferred that the patient's defenses are poor and that he cannot cope with the invading organism and its toxic products.

Another unfavorable factor has been the infection with Type III pneumococcus. The mortality in patients infected with this organism has been as high as 50% and since the introduction of Sulphapyridine is still over 8%.

Last but not least is the pregnant woman suffering from pneumonia. In this group the mortality was high.

Summarizing the unfavorable factors, we may say that patients over 50, especially those suffering from constitutional diseases; pregnant women patients showing bacteremia; or spread of the infection to both lungs; those infected with Type III pneumococcus; those exhibiting signs of great toxicity, show these signs because of their inability to build defenses against the invading organism.

---

*Read at the New Britain Medical Society, November 16, 1939.

Mechanism of Recovery from Pneumonia

The final destruction of all the invading organisms signalizes the complete recovery from pneumonia. This does not occur until enough anti-serum is elaborated in the body. The function of the antiserum as Fleming[1] and Long[2] have shown is to cause the protective capsule of the pneumococcus to swell and break. The liberated pneumococcus then becomes readily vulnerable to phagocytosis. The process of recovery from pneumonia therefore involves adequate antiserum production and active phagocytosis. It follows, that a patient who cannot build antiserum fast enough to combat the multiplication of the invading pneumococcus may show rapid spread, or invasion of the blood stream, or high toxicity; the very signs we have recognized above as unfavorable. Furthermore, it is obvious that such a patient can recover only if he receives a sufficient amount of antiserum, or if we can stop the multiplication of the organism, or both.

Problems Associated with Serum Therapy

With the introduction of type specific serum dramatic cures were effected in the first 24 or 48 hours of the disease in certain of the types and many patients with definitely unfavorable factors were cured. Nevertheless, the procedure of serum therapy created new problems to overcome.

First, of course, was the necessity of absolute accuracy in determining the correct specific type. That meant the importance of obtaining a fresh, warm specimen and immediate examination.

The second problem was the determination of serum sensitivity. A history of allergy or of former serum administration in the patient must be investigated. Especially in children who have received T+ A for Diphtheria is this important. To determine sensitivity we employ both the intradermal test by injecting 0.1 c.c. of 1:10 dilution of horse serum and the opthalmic test by installing two drops of 1:10 dilution of the serum into the conjunctive. A large wheal with pseudopodia or an active conjunctivitis indicates serum sensitivity. In such instances, of course, it is far better to resort to Sulphapyridine at once.

Thermal Reactions

About one in five of all serum treated patients show a thermal reaction following horse serum administration. Because of this, serum should be withheld from patients with a temperature of 104° or over until the temperature has been brought down — first by alcohol sponging, or with aspirin, or both. It is important to observe this rule in order to avoid dangerous elevations of temperatures to levels of 106° or over. Another safeguard in serum therapy is to have a syringe ready with 1:1000 adrenalin for instant use in case of anaphylactic reactions. Some may be so violent that there is no time to lose in administering the life-saving adrenalin.

It is obvious that specific antiserum is useful only if accurate typing has revealed the exact specific type that is responsible for the pneumonia, without which, serum therapy must frequently miscarry.

The determination of the specific type is only the first step, since the type of invading organism may be one for which serum is not available. For example, there is no horse antiserum for the higher types like XII and XIV, and that produced for III is not of very high titre. It is, therefore, in these types that rabbit serum will probably come to be employed when serum as well as Sulphapyridine is indicated by the gravity of the case. In fact, rabbit serum, being more concentrated and much cheaper, may be expected to replace horse serum in the other types as soon as it is freed of its toxic substances, a process already accomplished by the Rockefeller Institute and the Squibb Laboratories.

Sulphapyridine

The introduction of Sulphapyridine by Whitby[3] in experimental pneumococcus infections in mice, quickly led to its clinical application. Among the first reports was that by Evans and Gaisford[4] on one-hundred unselected patients with pneumococcus pneumonia, in which the ordinary mortality of 23% was reduced to 8%. This was quickly followed by similar studies in all parts of the world, which fully confirmed the remarkable specificity of Sulphapyridine in pneumococcus infections. In the Grace Hospital, New Haven, we have treated over 70 pneumonia patients with Sulphapyridine with only four deaths, and of these, one was caused by a streptococcus and one by a yeast infection (Cryptococcus) with all lobes involved. Of the pneumococcus pneumonias, therefore, we had but two deaths in 68, or about 3% mortality. When we compare these figures with a general average in former years of around 30%, the results are truly startling.

Mechanism of Action of Sulphapyridine

When mice experimentally infected with pneumococci are treated with Sulphapyridine, many will recover (Whitby, — Fleming, — Long), but many also will die unless they receive type specific antiserum in addition to the Sulphapyridine. From studies such as these, the opinion has grown that the Sulphapyridine acts upon the pneumococcus to slow down or arrest its growth and multiplication, but it does not destroy it. Its destruction will still depend upon the elaboration of a sufficient amount of antiserum and phagocytosis of the pneumococcus which has lost its capsule by the action of antiserum. Since mice do not form antiserum readily, a goodly number die unless they also receive antiserum.

Man, however, differs from mice in that he possesses naturally and can readily elaborate antiserum in the course of a pneumococcus infection. For this reason, pneumococcus infections in man may be expected to yield more easily to Sulphapyridine alone than is the case in the mouse.

Clinical Patients in Whom to Consider the Combination of Serum and Sulphapyridine

A. Patients Unable to Form Endogenous Antiserum.

Not all clinical cases of pneumococcus pneumonia develop enough antiserum to recover during Sulphapyridine therapy alone. These may be recognized simply: Patients who do not respond by crises in 24 to 48 hours after Sulphapyridine administration; Those that show the presence of unfavorable factors, such as bacteremia, bilateral involvement, rapid spread, high toxicity, and constitutional disease, especially in patients over 50. Such patients evidently are incapable of forming sufficient endogenous antiserum and may require type specific serum as well as Sulphapyridine.

B. Patients Infected with Strain of Pneumococcus Resistant to Sulphapyridine.

In all experimental studies on mice it was apparent that some strains of pneumococci were resistant to the action of Sulphapyridine. In this respect they behave more like staphylococci then pneumococci. The type of pneumococcus was not significant, but it had something to do with the individual characteristics of special strains. In Long's studies on mice, 2% of the strains studied were found resistant to Sulphapyridine. If this same experience may be translated to man, some patients suffering from pneumonia may not recover when treated with Sulphapyridine alone. For this reason, early recognition of Sulphayridine inadequacy is important. If after 36 to 48 hours the temperature has not become normal, although the blood level of Sulphapyridine is around 4 mg. per cent, one should conclude that the Sulphapyridine alone is inadequate and if type specific serum is available it should be administered promptly.

C. Patients Vomiting and Unable to Take Sulphapyridine.

Patients early in the disease, who are vomiting and are unable to retain anything taken by mouth, must either receive Sulphapyridine parenterally, or if infected with a type of pneumococcus for which there is a potent antiserum available, may receive serum, with the certainty that if enough is administered a crises may be expected within twelve hours. When a readily soluble salt of Sulphapyridine becomes available its parenteral use however, will solve this difficulty in many patients.

D. Certain Selected early Patients.

Early patients with pneumonia with type specific serum available for the particular organism and able to pay for its use, may continue to be treated with serum alone. There are certain advantages; there is but one dose administered; crises and cure result immediately; vomiting and toxic signs of Sulphapyridine are avoided; treatment does not have to continue for eight days. Such considerations will not permit the total abandonment of serum in all early cases.

E. Patients Who Develop Toxic Signs of Sulphapyridine.

While nausea and vomiting is not a contraindication to Sulphapyridine administration, severe vomiting may necessitate its administration parenterally. However, the development of agranulocytosis, hemolytic anemia, jaundice, dermatitis and gross hematuria, require that the drug be discontinued and treatment with serum instituted if possible. It is, of course, obvious that to recognize such possible complications requires the close study of the patient at least twice a day as well as daily blood and urine examinations.

F. Pneumonia Not Due to Pneumococcus, but to Staph-Aureus, or Tuberculosis, or Virus

Pharmacology of Sulphapyridine

Long's studies indicate that only 50 to 80% of the Sulphapyridine injected is excreted in the urine. This excretion is not complete until 48 to 97 hours after injection. Futhermore, its excretion occurs in two forms, the acetyl Sulphapyridine, which can only stay in solution in an alkaline medium, and the free Sulphapyridine. Since acetyl-Sulphapyridine may precipitate in the kidney, forming nephroliths of various sizes which can block kidney tubules and cause gross hematuria and lead to uremia, the observation of the urine for presence of gross blood is necessary. Some even administer bicarbonate of soda with the Sulphapyridine to assure an alkaline reaction to the urine. There is, however, no evidence what ever that this procedure truly prevents acetyl Sulphapyridine nephroliths.

Acetyl Sulphapyridine is formed in the body to detoxify the drug and, in fact, once acetylation has occurred, this form no longer has therapeutic value against the pneumococcus. It is therefore important that the free Sulphapyridine level of the blood be known, as this alone is the measure of its therapeutic value.

Therapeutic Level of Sulphapyridine in the Blood

In our cases, we found great disparity between the blood level and therapeutic result. Many patients had a Sulphapyridine level of the blood of no more that 2 mg. per 100 c c., but promptly recovered by crisis. This finding is generally recognized by most authors in the literature. However, a level of 4mg. per 100 c.c. is considered optimal.

Technique of Administration

Our method has been to administer the crushed tablets in fruit juice or milk. An initial dose of 1 gm. is followed one hour later by another gram, and this is continued every four hours day and night. If severe vomiting occurs, two gms, of the drug is dissolved by adding it to 1500 c c. of 5% glucose in saline, which has first been brought to a boil. The solution is then allowed to cool and given subcutaneously at body temperature. Probably when sodium Sulphapyridine is available, its easy solubility will make its intravenous administration feasible. Daily blood levels of free Sulphapyridine are taken to determine whether the patient has developed an optimum blood level.

The drug is then continued until the temperature has been normal for two days, after which it is given every six hours instead of every four until resolution is well advanced. At this stage the dose is reduced to ½ gram every six hours until at least eight days following the onset of the illness have passed, for it takes about that length of time for the body to build up enough antiserum to destroy all the pneumococci. When the temperature falls and vomiting sets in, there is great temptation to stop the drug prematurely. This however, should be resisted in order to avoid recurrences.

General Measures

a. Fluid intake is kept up between 3000-4000 c.c. daily.

b. Oxygen has been very rarely used since the above therapy was employed. However, if a patient comes under observation late in the disease, is toxic and cyanotic, we employ oxygen.

c. Digitalis is not used unless the patient required it and took if before the pneumonia set in.

d. For pain we have used morphine, local heat, and at tmes adhesive plaster.

e. Food: The illness is so short usually that diet is not very important; however, we have merely given high calorie, liquid diet, similar to a typhoid diet,

f. Circulatory collapse, although rare, usually is an early symptom, sometimes ushering in the pneumonia; occasionally it is a late symptom preceding death. When it occurs early in the disease, large quantities of intravenous fluids as well as a large transfusion may be life saving. When it occurs late, it is usually a grave sign of impending death and rarely susceptible to treatment. The mortality in pneumonia has been so reduced by the use of Sulphapyridine and serum that we now rarely see patients with failing hearts late in the disease.

Management of a Case

1. We first determine whether it is pneumonia. If the physical signs are doubtful, we resort to an x-ray when possible.

2. What type is it? A fresh sputum specimen is rushed to the laboratory and typed by the Neufeld technique.

3. A blood culture is taken before therapy is instituted because growth in culture may be

arrested by blood Sulphapyridine.

4. Blood count and urine examination are ordered.

5. If patient is not vomiting seriously, Sulphapyridine, one gram crushed, is given in fruit juice or milk, then repeated in one hour and every four hours thereafter day and night.

6. Determine the day of the disease. If it is the first day of illness we give Sulphapyridine. If severe vomiting is present, we use instead type specific serum 100,000 units after determining that the patient is not serum sensitive. Whether we use horse or rabbit serum will depend upon the type of pneumococcus, serum availability, and the patient's sensitivity.

7. Appraisal of the presence of unfavorable factors: If we are dealing with a pneumococcus on the third day; if leukopenia is present; if bacteremia with more than one colony per c.c. is found; if the patient is very toxic and critically ill; if he shows bilateral involvement and rapid spread of the process, then we administer Sulphapyridine and also type specific serum when available.

8. Daily observations on blood, urine, and observations every other day on N.P.N. are made.

9. If after 48 hours of Sulphapyridine therapy, there is no improvement, we recheck the sputum and the blood, and administer serum when possible. However, it should be remembered that in such an instance we may be dealing with a yeast or a streptococcus or a staphylococcus or tuberculosis bacillus infection, and not with a pneumococcus pneumonia at all.

10. If the temperature returns promptly to normal we continue Sulphapyridine two days, then administer it every six hours until resolution is well advanced, then reduce the dose to ½ gram every six hours, and after eight or nine days of illness we discontinue the drug entirely.

11. Throughout this period we take care that resolution is complete before discharging the patient, since a rare case will develop empyema while the temperature remains normal.

12. Patient is allowed up after seven days of normal temperature.

REFERENCES

1. Fleming, Alexander: The antibacterial power of the blood of patients receiving 2-(p-aminobenzenesulfonamido)-pyridine, Lancet, (September 3), 1938, ii. 564.

2. Long, P. H., and Wood, W. B., Jr. Observations, upon the experimental and clinical use of Sulfapyridine. II. Treatment of pneumococcal pneumonia with Sulfapyridine, Ann. Int. Med., 1939, xxiii, 487-513.

3. Whitby, L. H.: Chemotherapy of pneumococcal and other infections with 2-(p-aminobenzenesulfonamido)-pyridine, Lancet, (May 28), 1938, i, 1210.

4. Evans, G. M., and Gaisford, W. F.: Treatment of pneumonia with 2-(p-aminobenzenesulfonamido)- pyridine, Lancet, (July 2), 1938, 11. 14.

* * *

OPTOMETRY AND THE EYES OF SCHOOL CHILDREN

School physicians and nurses discover many cases of defective vision, and advise the parents to take the children to a physician for diagnosis and treatment. This advice is important, because many cases of defective vision are caused by pathological changes in the eye itself, or some disturbance elswhere in the body, — conditions which an optometrist is incapable of diagnosing or treating. The physician is the proper one to decide whether an individual case needs the services of a specialist and what kind of a specialist.

Futhermore, in many cases of refractive error, especially in young children, no one can make accurate examination without the aid of a cycloplegic ("Drops"), a procedure which optometrists cannot legally employ.

Since an accurate diagnosis is a necessary preliminary to any treatment, the school nurse is legally required to advise the parents of a child to have a diagnosis made by a licensed physician for only he is empowered to make a pathological diagnosis and to prescribe drugs and operations for relief.

Jour. Med. Soc. N. J. Aug. 1939

The PROFESSIONAL EQUIPMENT Co. X-RAY SUPPLY *and* SERVICE SPECIALISTS. KELEKET APPARATUS. TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

The Short Cyclopegia for Refraction*

S. JUDD BEACH, M.D.,
Portland, Maine

It is entirely possible to do away with the necessity for repeated instillations of cycloplegics for refraction. This is a boon to the patient and physician alike. In addition to abating the annoyance of multiple administration, single dosage greatly shortens the period of recovery. Two years' experience indicates that this can be accomplished without serious violence to the accuracy of the examination. I have been asked briefly to answer some of the questions we are asked about the method.

It will be recalled that in 1937 Myerson announced a synergy between benzedrine and atrophine such that single doses of the two drugs use together will induce complete cycloplegia of short duration in doses totally ineffective if used separately. It should be said that this work has been challenged by a few observers. While their conclusions involve some unproved assumptions they have not yet been controverted so that the question is still unsettled. However, Myerson's work inspired McAdams and me to make some experiments with cycloplegics and benzedrine. We found that by using them together satisfactory cycloplegia can be obtained with a shortening both of the dosage and the recovery. While it is important for scientific reasons to know the reason for this phenomenon, it is fortunately not indispensable for practical use. It might, as Myerson supposed, be due to an actual synergistic action upon accommodation. It might also be explained as inducing an increased permeability of the cornea to the drug such as has been claimed for cocaine in combination with homatrophine. It might merely result from the action of benzedrine in reducing the sensitivity of the cornea and in lessening the secretion of tears, thus overcoming the tendency to wink away and flush out the drops.

My own custom has been to employ our regular strengths of the cycloplegics, 1% in case of atropine and 5% (not 2%) for homatropine. I instil one drop of the cycloplegic, then follow in a couple of minutes with a drop of 1% benzedrine and finally in two minutes more repeat the cycloplegic. This makes the entire medication take less than 5 minutes. As the benzedrine opens the lacrimal duct I am accustomed to hold the puncta after instilling the second drop of atropine. Since doing this I have not even observed flushing after the instillation. No precautions are necessary with homatropine. The effect of homatropine begins to wear off soon, so the refraction should begin in about 50 minutes. With atropine it can be deferred a little longer.

The advantages of the method are obvious. In using homatropine patients do not have to wait around for an hour and a half, submitting to one instillation of the drug after another. After the instillation they can go out, if they like, for half an hour or so. The great advantage, however, is that a student in the midst of examinations, or a business man, or stenographer can be examined in the afternoon with a reasonable expectation of being at work the next day. This technique is especially advantageous in administration of atropine. It does away with the necessity of sending home a potent drug for instillation by incompetent parents. Furthermore it obviates the necessity of a second visit which must be made at a fixed time regardless of convenience or storms and often from a long distance. Finally recovery takes place in a few days, so that it is possible to examine a school child at the end of the school week on Friday with the expectation of a return to class early the next week.

The convenience of this shorter cycloplegia has almost entirely done away with those objections by patients to use of "drops" which used to be common in our practice.

It is properly asked how near we come to getting as complete cycloplegia in this way as we would have obtained with the orthodox method of repeated instillation. We have made comparison of dozens of eyes, using one method at one time, and later, after complete recovery, employing the other in the same patient. With homatropine we could find no difference. In a given case one method might be more effective but in another the reverse held true, in the same degree.

---

*Read at 147th Annual Meeting, Connecticut State Medical Society, New Haven, May 25 and 26, 1939.

With atropine, we averaged about a quarter of a diopter deeper cycloplegia with the customary multiple instillations. This advantage is so trifling that it has not tempted us to return to the old method.

Now what can be said on the other side? First as to contradictions. We know of none. We have neither had nor heard of any disturbance due to benzedrine. Two objections however, have been urged. The first is that so much care has to be given to instillation. This a legitimate criticism. Where everything hangs on one or two drops it must be certain that they take effect. They cannot be slopped in by some careless attendant. We see to it that the eye is held level, so that the drop spreads over the cornea, and that the lid does not snap down and flip it off. The other objection seems to us less valid. It is made by those who have been disappointed in the results. In many instances we suspect that they would be equally disappointed with the results of the classical method it they had taken pains to make an accurate comparison.

Most men from whom we inquire have never taken the trouble to find out that no sort of cycloplegia is really dependable. In a recent survey of case reports in refraction submitted by candidates for the certificate of the American Board of Ophthalmology it turned out that only 13% mentioned testing the depth of cycloplegia. If this were done oftener those who properly distrust the benzedrine method might be surprised to find that no more reliance can be placed upon conventional cycloplegia. After a comparison of the results in many cases our impression is that about the limit of cycloplegia in the most individuals is obtained by the first drop provided it is instilled with care. Subsequent doses add little to the intensity of cycloplegia, and paradoxically in some cases even seem to have the opposite effect. They do however, protract the recovery. This suggests the possibility that what is cumulative is not the depth but the duration of the cycloplegia.

The fallibility of the most thorough methods of employing cycloplegics is shown by a study of 2500 eyes examined for refraction in our private practice.

Omitting many other interesting aspects, this study showed that routine cycloplegia is quite undependable. In about 50% of cases it will overlook an error of .50D., .75D., or 1. D. This is not intended as a criticism of cycloplegia. Far from being a drawback it is probably a safeguard. If the accommodation were absolutely flattened out by drugs, patients would probably be continually over corrected. This lack of reliability appears vividly in cases like one where after conventional 3 day instillation of atropine a 5 year old child with a squint showed only +2.50D. (with a cylinder) in each eye. The following year under atropine the error was found to be about double. It was +4.50 (with a cylinder) in the right eye, and +5.25 (with a cylinder) in the left. In other words, the universally approved cycloplegic technique had failed to disclose 2 and 2.75 diopters of hyperopia. Cycloplegics with benzedrine cannot fairly be expected to give more reliable results, but it is our experience that on the average the older method has not much advantage over that with benzedrine. We always try to ascertain the depth of our cycloplegia. Adding a +3. lens to the prescription as revealed by the cycloplegic should theoretically give a nearpoint of 13 inches or 33 cm. If the nearpoint with a +3. added is 11 inches or less, as may happen, or the addition of a weaker lens like +2.00 gives the 13-inch near point we know that cycloplegia is incomplete. In that case it is still possible to go right ahead with conventional cycloplegia, instilling the additional drops that would have been used regularly. But as I have said, at our hands, the result has usually been disappointing.

Before leaving the subject, I ought to answer a question that is naturally asked. That is whether paredrine, which the manufacturers are now supplying, is as satisfactory, as benzedrine. Unfortunately our experiments were made entirely with benzedrine. Tassman who has reported on paredrine considers it effective. So far as we have used it the results have been satis-

(*Continued on Page 182*)

Association of Connecticut Tumor Clinics

Fourteenth Meeting of the Association Held at Lawrence and Memorial Associated Hospitals, Inc., New London, November 3, 1939

Doctor Carl H. Wies, chairman of the tumor clinic, stated that the clinic had been started at the request of the State Tumor Committee and the Cancer Division of the State Department of Health three years ago, but that the local doctors are not showing any great amount of interest in it due to the fact that the hospital is not equipped with a deep x-ray therapy machine or radium and, consequently, all cancer cases requiring therapy treatment never enter any hospital or else are referred to other hospitals where proper treatment can be obtained.

Doctor Daniel Sullivan remarked that he hoped this deplorable situation would be corrected in the near future because a bequest of $400,000 had been left to the institution, and it was the intention to allot a portion of this sum for the proper care and treatment of cancer cases.

1. Carcinoma of the Breast

Doctor George C. Cheney reported that there have been 48 cases of carcinoma of the breast admitted to the hospital in the past five years, and one half of these cases are still living.

Doctor R. R. Agnew of Norwich reported that Backus Hospital has had 44 cases of carcinoma of the breast during the last five year period, and these figures show that apparently better results are being obtained by treating the patients with a combination of x-ray and surgery rather than surgery alone, especially in those cases that have palpable axillary metastases.

Doctor A. W. Oughterson of New Haven stated that according to reports given at the New England Cancer Society meeting November 2, the same final results are being obtained in the treatment of cancer of the breast by simple mastectomy with the axilla treated by implantation of radium and later supplemented by deep x-ray therapy as by radical amputation. He also stressed the point that patients with cancer of the breast who are still menstruating may not expect any extension of their lives if they are given a supplementary sterilization dosage of deep x-ray therapy to their ovaries, but many of these cases will show a markedly improved general health for some period of time after this sterilization, and when they finally begin to succumb to their metastatic growths they will go down hill much more rapidly. He gave a case in point showing that an apparently hopeless case of cancer of the breast in a young woman with numerous skeletal metastases who was given x-ray sterilization enjoyed markedly good health for two years following this procedure.

Doctor Edward J. Ottenheimer of Willimantic supplemented Doctor Oughterson's remarks about the effect of the menopause in metastatic breast malignancy by citing a case in which a natural menopause was responsible for a marked temporary regression of metastases.

A 45 year old woman had a cancer of the breast which was treated by radical amputation and followed by deep x-ray therapy. Two years later she developed cough and dyspnoea and x-ray examination showed definite pulmonary metastases. Fluid in one side of the chest appeared and she was jaundiced and the liver was definitely enlarged. It was felt that the tenure of her life would be very short and no x-ray therapy was given, but a natural menopause intervened and the patient began to gain weight, the jaundice disappeared, the liver became smaller, and her dyspnoea and cough cleared up. Her general health was markedly improved for one year and then her symptoms recurred and she died of extensive metastases.

Such striking cases as these suggest that it is well worth while to continue to sterilize these young patients with cancer of the breast, because it does improve their health for an appreciable period of time although it may not lengthen their lives.

Doctor Ottenheimer further reported that at the Massachusetts General Hospital all breast cases since 1890 have been analyzed and have been recorded in five year periods up to the present time. In 1890 and for the subsequent five years only 19% of the total breast cases were living and well at the end of five years, whereas in the last five year period ending in 1934, 35% of the total cases were living and well at the end of the same period of time. The percentage of cases coming into the hospital in stage 1 (the stage where the lesion is confined solely to the breast and has not metastasized) is approximately the same in 1934 as it was in 1890. The improvement in the results being obtained now is probably due to better treatment and not due to the fact that more early cancers of the breast are being seeen than were seen forty years ago. It is more or less universally recognized that the great majority of early cancers of the breast can be cured and the problem today is the same as it was forty years ago. If more cancers are to be cured by our present means of therapy we must get a greater percentage of them in the early stage, and this can be done simply by means of annual physical examinations by competent physicians.

Doctor Joseph O. Collins of Waterbury reported that for the last four years it has been the practice in the Waterbury Hospital to sterilize young women with breast cancer, and cited a case to prove his point. Another point that he emphasized was that preoperative x-ray therapy is not justifiable unless a definite diagnosis of cancer has been made by biopsy. If this is not done, needless and perhaps harmful radiation therapy will be administered to patients who have only benign tumors. If a negative aspiration biopsy is obtained, a larger piece of the suspected tissue should be removed surgically and examined by frozen section, and if proven cancerous the patient should be immediately subjected to adequate cancer therapy.

Doctor Kenneth K. Kinney of Willimantic reported that in his hsopital patients with carcinoma of the breast had been sterilized routinely for the past four or five years when they had not passed the menopause. He cited a case in illustration of the beneficial results obtained.

2. An Unusual Case of Melanoma

Doctor Frederick Hartman presented a patient and read the case history as follows:

In 1911, Mrs. W., now 69 years of age, a white native-born woman, went to Dr. Capron of Providence for refraction, and he noted some peculiar brownish spots on the palpebral and ocular conjunctiva of the left eye. However, as these had been present at least eight years without change, no importance was attached to them. The patient showed some neurological signs, such as left sided weakness, ptosis of left lid and left foot drop, all of which were said to have followed poliomyelitis. Examination of the fundi showed no evidence of tumor or pressure.

About 1912, she noticed a bean shaped tumor of the left eye measuring one-half by one-third of an inch. Two ophthalmologists advised immediate removal, which was done. The tumor was freely movable and at no place seemed to have invaded the sclera. The pathological report was melanosarcoma.

In December, 1914, she was again seen by Dr. Capron complaining of a series of corneal ulcers on the left, all of which healed except one, and this gradually became elevated and pigmented. Enucleation was performed and the tumor, although it invaded the cornea, did not penetrate into the interior of the eye or through the sclera. The pathological report was again melanosarcoma.

Twenty-four years later, in 1938, she presented herself at the Lahey Clinic complaining of a gradually increasing lump behind her left ear, first noticed three years before. Just before coming to the clinic she had received radiation of unknown amount. A specimen for biopsy was taken and revealed epidermoid carcinoma, slow-growing. Partial excision and implantation of radium was done and the tissue removed showed a rapidly growing malignant melanoma. Again her neurological symptoms were causing complaint. She was having frequent attacks of paroxysmal coughing and choking coming on during sleep, and following these spells headache and weakness. Examination showed no evidence of increased intracranial pressure and the attacks were unexplained. Since then, she has continued to have these attacks which are the most distressing part of her illness. She has a chronically draining sinus at the site of the radium implantation and has become more and more hoarse. There has now developed a fifth nerve palsy. Her gag reflex remains intact but the tongue deviates to the left. The urine has been found to contain melanin. The liver was never felt to be enlarged and the patient seems to be holding her weight, although her general course is downhill.

The question arises as to whether this is the same tumor which has been present for thirty years, or an entirely new process. Adair cites a case of melanoma of the eye with the first sign of metastasis occurring in the liver 25 years after enucleation, and Newton reports a case of a 34 year old man with a similar tumor who had a local recurrence 12 years after enucleation. Another question one might raise is whether the neurological signs are related, and if so, could she have had this as a primary lesion. This seems unlikely due to the duration of the disease.

This case demonstrates the following important points:

1. The need for early, complete and careful excision.

2. The necessity for a guarded prognosis. A five year cure does not mean a true cure.

3. The need for careful pathological examination of the tumor. As in this case, different parts of the same tumor may lack pigment and other characteristic findings. Adair in his series of 400 cases found that nonpigmented melanomas are usually of high grade malignancy and are many times mistaken for benign tumors.

4. Radiation has been found to be of very little value in these cases. Adair has a 2.5% survival for five years. Radiation probably would not have been given in this case had the pathological report been known. It is generally conceded that treatment given prior to a preliminary biopsy is to be frowned upon in the case of any tumor. If there is to be progress and correlation made between treatment and curability, it can only be made on the foundation of an exact diagnosis.

5. This patient's first recurrence followed a series of corneal ulcerations. One might speculate as to whether there is any correlation, but there seems to be more than a casual relationship between trauma and an activation of malignant process in these tumors. Injuries reported are varied, such as hypodermic injection through a quiescent mole, cutting a nevus while shaving, and perhaps an even greater hazard is the use of dessicating currents by beauticians.

6. The last point is the question of biopsy. In this case there probably was no other way to determine the nature of the growth and it is doubtful if biopsy had any relationship whatever with the course of the disease. However, biopsy is felt by most people to be dangerous and may be the exciting factor in starting a malignant change or distributing metastatic cells. Excision is the preferable method.

A summary of the points to be remembered in the treatment of melanosarcoma follows:

1. Pigmented spots are common, each person having an average of twenty. Melanosarcoma is not common, occurring in Adair's series in but one of every twenty cases of skin cancer, but it is one of the most malignant tumors known.

2. Any pigmented nevus which starts to grow, becomes elevated, or contains black pigment should be treated with suspicion.

3. Excision of any nevus which is subject to repeated irritation should be advised.

4. Lesions suspected of being of this type should not be biopsied, but excised widely, usually down to the fascia.

5. A careful pathological diagnosis should be made on every excised tumor.

6. General anesthesia should be used as it is believed that the manipulation of injecting novocaine may cause dissemination.

7. If the excised tumor proves to be malignant, a careful dissection of the regional lymph nodes should be done. Some authorities feel this should immediately follow excision (Holmes and Daland), while others (Adair, Memorial Hospital group) suggest waiting two weeks in order to stop any disseminated cells at the first barrier.

8. Prognosis must be guarded as late and distant metastases occur.

In Adair's series, 33% of primary operable cases and 27% of recurrent cases survived the five year period. Daland and Holmes report a series of 147 cases with 9% cures in cases with regional lymph node metastases, and 25% in primary cases without regional node involvement. Welch, in the American Journal of Cancer, reports the average life expectancy in inoperable cases as 39 months.

Our chief hope of improving the percentage of patients lies in the removal of moles containing black pigment, as a prophylactic measure, and more and earlier surgery should be employed rather than less in an attempt to accomplish this.

Doctor Oughterson called attention to the fact that melanomas may be of two types, the pigmented and the non pigmented. He re-emphasized the danger of treating these pigmented moles by high frequency current or acids. The mole should be removed surgically, taking a wide margin of normal tissue around the lesion.

3. Carcinoma of the Cervix

Doctor Wies reported that there had been only seven cases of cancer of the cervix in the Lawrence and Memorial Associated Hospitals in the past five years, of which two are living.

Doctor Agnew reported that 44 cases of carcinoma of the cervix had entered the Backus Hospital in Norwich in the past five years, and that it was difficult to persuade the local physicians to treat these lesions according to the methods recommended by the Therapy Committee of the State Tumor Committee. The number of cases is small and the methods of treatment are so diverse and the time interval is of such short duration that no statistics of any value can be deducted from these cases.

In response to a question as to whether or not surgery following x-ray and radium therapy is often employed, Doctor Oughterson replied that the best method of treating cancer of the cervix was by the use of x-ray and radium. Surgery had little or no place except in an occasional early case where the lesion could be easily removed by wide excision. Even in these cases it might as a rule be better to use the usual treatment as advised by the Therapy Committee of the State Tumor Committee, and there is certainly no place for surgery in cancer of the cervix after x-ray and radium therapy has been applied.

Doctor Kinney reported that in the series at the Backus Hospital beginning six years ago they have very few five year cures that have been obtained to date, but there are a number who have already gone three years since treatment, and it has been shown by Dresser and others that most cases living three years after treatment will still be alive at the end of five years. He said that the routine used in the treatment of carcinoma of the cervix is that outlined by the Therapy Committee of the State Tumor Committee. This plan is to give first of all divided adequate x-radiation through four portals to the pelvis, then four weeks after the end of x-radiation adequate intra-uterine radium application, and one week thereafter to apply radium against the cervix. If excessive shrinkage of the vagina is noted during x-radiation, treatment should be interrupted and intra-uterine and vaginal radium applications should be given and after this the x-radiation completed. In the treatment of advanced cancer of the cervix x-radiation should almost always be given first, but occasionally in the early stages radium may be used first and later followed by x-ray therapy.

Doctor Charles L. Larkin of Waterbury remarked that it was correctly stated that the State Tumor Committee and the Cancer Division of the State Department of Health requested that a tumor clinic be organized in the Lawrence and Memorial Associated Hospitals, Inc. It is the opinion of the men forming these committees that if a tumor clinic is started in any hospital and this tumor clinic joins and enters into the activities of the Association of Connecticut Tumor Clinics, it will not be long before this clinic will recognize its shortcomings in the handling and treatment of the cancer cases which have been coming into that hospital in previous years. Knowing their lack of facilities, such as deep x-ray therapy machines and an adequate amount of radium, it will not be long before the authorities in charge of the hospital will see to it that this lack of equipment is remedied.

He noted that Doctor Wies stated that many cases of cancer in New London never reach the Lawrence and Memorial Hospitals because the physicians in the town already recognize the fact that the hospital is not equipped to take proper care of them. Also Doctor Sullivan has informed the meeting that the sum of $400,000 has been left to the hospital, that this may be used for cancer work, and that the hospital already has $200,000. It would seem that the Lawrence and Memorial Associated Hospitals is already in a position to buy the proper equipment. There does not appear to be any need to wait for the other $200,000 because all that is necessary is a deep x-ray therapy machine, which could be housed in the present building, and 100 mgms. of radium, both of which could be bought for a total expenditure of not over $25,000.

Apparently only seven cases of carcinoma of the cervix have been admitted to the hospital during the last five years, but these cases could not have been given what the Therapy Committee believes to be adequate treatment, and it seems too bad in this day and age to give inadequate treatment to even seven patients.

Doctor Kinney has outlined the plan of treatment for carcinoma of the cervix as advocated by the Therapy Committee of the State Tumor Committee. This outline, which includes treatment for cancer of the fundus of the uterus and cancer of the breast, has been sent to every tumor clinic in the state and a request has been made to put it in a prominent place in the staff room or tumor clinic room where it can be readily available for reference. The treatment of these three common cancerous lesions has been standardized by this committee and it is hoped that it will be followed so that at the end of a year or five years or more the Cancer Division of the State Department of Health, when compiling the records of all cancer cases, will be able to tell exactly what the results are after using these standard methods, and to compare these results with those obtained in other states or clinics.

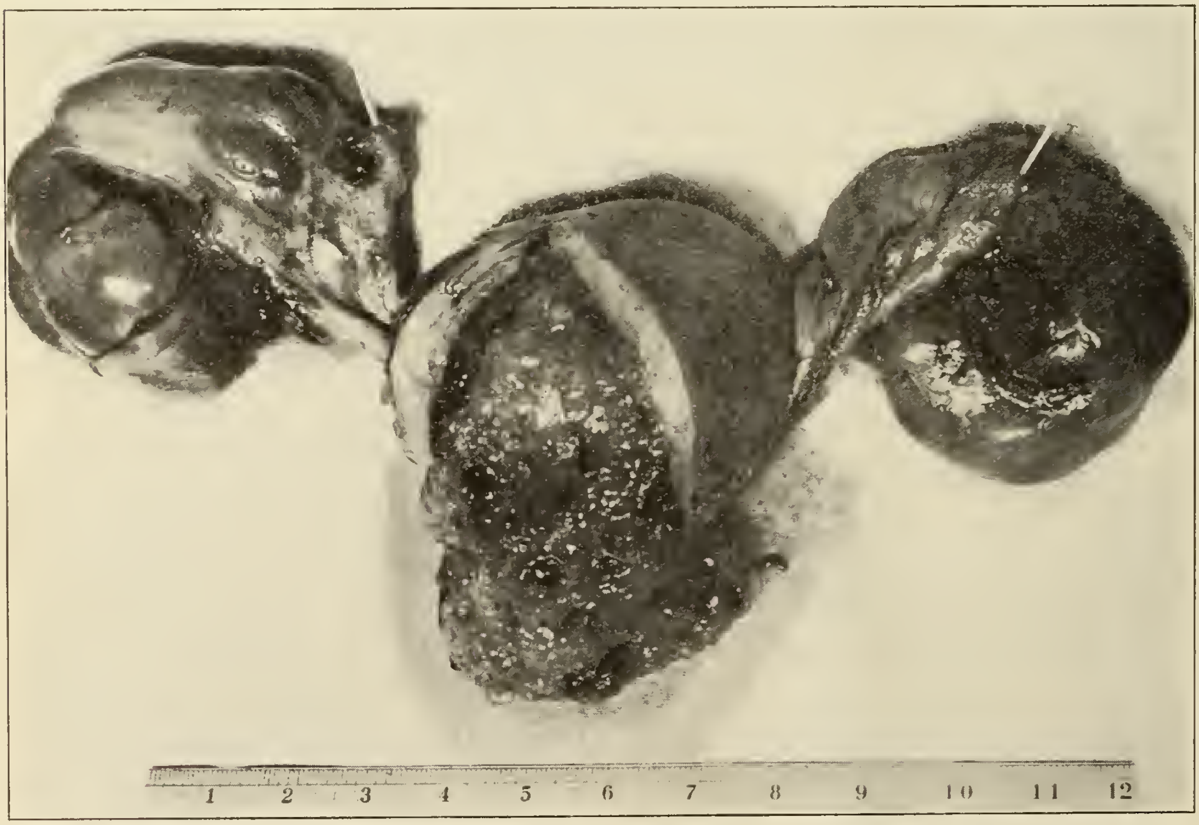
The Cancer Book which is being put out by the Publicity Committee is now in the hands of the printer and it will be available for distribution to every physician and medical student in the state in the near future.* This book contains the thoughts and recommendations on cancer of the best men in this state and it is hoped that when received it will be used by all physicians for quick reference.

4. Case of Hydatid Mole

Doctor Larkin then presented a case of hydatid mole which is of considerable interest because the history and physical findings led to an incorrect diagnosis, and the pathology found at operation made it necessary to treat the patient radically rather than conservatively.

The patient, S. J., was a 25 year old white married female admitted to the Waterbury Hospital, October 1, 1939. Her chief complaint was vaginal bleeding of two weeks duration. Her menstrual cycle was usually regular, every 25 days, lasting four days with very slight discomfort, but her last period had been about July 1st. After eight weeks of apparently normal pregnancy she started to have vaginal bleeding and this contineud and became so profuse that at the end of two weeks she entered the hospital. Ascheim Zondek Test was positive. Physical examination showed the uterus enlarged to the size of a ten weeks pregnancy but the uterus was retroverted and wedged posteriorly. The physician in attendance thought the retroversion was causing a miscarriage and after the uterus was dislodged from its posterior position and held in place by a proper fitting pessary the bleeding stopped and the physician allowed the patient to be discharged home.

Three weeks later, October 1, the patient was readmitted to the hospital complaining of recurrent bleeding and severe pain in the lower abdomen. She looked and acted extremely sick. Her color was poor, and her pulse was rapid and thready. She was in agony due to the pain in her lower pelvis. Pelvic examination showed the cervix to be pushed up behind the pubis so far that the os could not be seen. Palpation revealed two large irregular masses which had the consistency of ovarian cysts wedged



---

*As the Journal goes to press the Cancer Book here referred to has been distributed throughout the State.

down into the posterior cul-de-sac, pushing up a mass that felt like a uterus the size of a three months' pregnancy. Diagnosis of ovarian cysts with twisted pedicle and early pregnancy was made and an immediate operation was decided upon.

At operation it was absolutely impossible to get hold of the cervix with a tenaculum and a dilatation and curettage was out of the question. The bladder was catheterized and found not to be distended. The abdomen was opened from the umbilicus to the pubis. Two large ovarian cysts, one in each ovary and both the size of grapefruit, were found wedged down and firmly adherent in the posterior cul-de-sac and the enlarged uterus was riding on top of these masses. The ovarian cysts were freed up and were of such size that it was deemed extremely unlikely that they would ever recede to normal size and function, even if they were corpus luteal cysts of pregnancy. The uterus itself was enlarged the size of a three months' pregnancy but it did not have the consistency of a normal pregnancy. It was decided that, considering the amount of bleeding that had occurred up to the present, if it were a normal pregnancy the patient would undoubtedly abort and if it were a hydatid mole a hysterotomy would not be justifiable, because the patient was already in semi shock and could not afford to lose any more blood. It was considered poor judgment to open up the uterus and spread the contents into the abdominal cavity in case a malignant mole was inside, so a hysterectomy and double salpingo-oophorectomy were performed. The patient had an uneventful recovery and was dismissed home in good condition.

Remarks

In reviewing this case history, the question arises as to whether the attending should not have emptied the uterus at the time of the first admission to the hospital. If this had been done a correct diagnosis would have been made and the patient would not have suffered the loss of her female genitalia, but the patient wished to have a child and, as she had been married for four years, wanted to continue with her pregnancy if she possibly could. The physician, not being able to look into the future and see that the ovarian cysts would enlarge so rapidly and push the cervix up into a position where a dilalatation and curettage could not be performed, was undoubtedly justified in being conservative. The only possible way he could have made a correct diagnosis was by examining the vaginal discharge and finding hydatid cysts, but this is a procedure that is neglected by practically every clinic and was not resorted to in this case; or a quantatitive analysis of the Prolan A present in the urine might have been made, but this procedure is also not performed in this hospital. The only other question of procedure was whether or not the surgeon was justified in thinking that the ovarian cysts would not recede and become normal. This is a question that is open to dispute. The surgeon in this case did not believe that cysts of the size of these ever would be normal again, but if he had thought it possible he might have freed up the cysts, closed the wound and then performed a dilatation and curettage and removal of the hydatid mole. After the cysts had been removed from the posterior cul-de-sac it would have been entirely possible to have done this, but the condition of the patient was such that it was not believed she could stand any further loss of blood.

Doctor Donald A. Bristoll of New Britain reported that Dr. Schumann of the University of Pennsylvania would have agreed with the radical surgery done on this patient. He points out that 10% of hydatid moles become malignant and that they all ought to be removed where there is invasion of the uterine wall by syncytial elements or where there are many hemorrhagic areas present. Doctor Bristoll said that he had performed a radical operation on a similar case because of profuse hemorrhage, and a review of the literature at that time led him to believe that he had done correctly. Curtiss states that a hydatid mole should be regarded as a tumor of great potential malignancy and its removal should be conducted by such methods as will insure thoroughness of evacuation. Aldrich is in favor of a radical operation. Bleeding and brownish discharge, extrusion of vesicles, uterine enlargement and toxemia are signs of mole.

The meeting adjourned, following which dinner was served to the delegates by the hospital.

✡✡

BIRTH PREMIUMS IN FRANCE

Various measures designed to encourage an increase in the birth rate and to aid families are provided for in a French decree of July 29, 1939.

On the birth of the first visible and legitimate child in a family, the mother is to receive a birth premium, provided the birth takes place within 2 years after marriage and the child is of French nationality. The premium is to be an amount equal to twice the father's monthly wage or salary, but not less than 2,000 francs.

Child, Dec. 1939

State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

Some Data on the Reported Cases of Syphilis and Gonorrhea in Connecticut During 1939

HENRY P. TALBOT, M.D.,*
Hartford, Conn.

In this article are tabulations of cases of syphilis and gonorrhea reported in Connecticut for the year 1939. These cases are tabulated by county, various population groups and stages of these diseases. The cases are also tabulated for the five year period. The cases of syphilis and gonorrhea have declined considerably during the last two years. The largest number of cases of syphilis ever recorded at this department was in 1937 when there were 2,760.

The cases of syphilis and gonorrhea reported during the five year period, 1935-1939, will be noted in Table No. 1. The cases of gonorrhea have been on a constant decline, the smallest number being 1,168 reported in 1939.

TABLE 1—CASES OF SYPHILIS AND GONORRHEA REPORTED, 1935-1939

Year	*Syphilis*	*Gonorrhea*
1935	2,446	1,605
1936	2,494	1,523
1937	2,760	1,496
1938	2,424	1,310
1939	2,262	1,168

In Table No. 2 cases of syphilis and gonorrhea are tabulated by county with the various rates. The syphilis case rate for 1939 was 124.90 which was a slight decline over this rate for the year 1938 which was 135.49. The total gonorrheal, case rate was 64.49 as compared with the rate of 73.22 for 1938. As in previous years, the largest number of cases and the highest case rates were recorded in the counties of the larger population groups. In the year 1939 New Haven County reported the largest number of cases and had the highest syphilis case rate. It will also be noted that the largest number of cases of gonorrhea and the highest case rate occurred in New Haven County. In most instances, in the more rural counties both cases of syphilis and gonorrhea were reported in smaller numbers.

Table 2—REPORT RATES BY COUNTIES—PER 100,000 POPULATION

		Syphilis		*Gonorrhea*	
County	*Population*	*Cases*	*Rate*	*Cases*	*Rate*
Hartford	498.668	583	116.91	360	72.19
New London	131,916	139	105.37	73	55.34
New Haven	507,128	773	152.43	416	82.03
Fairfield	446,263	644	144.31	235	52.66
Middlesex	54,847	32	58.34	32	58.34
Windham	54,086	30	55.47	17	31.43
Litchfield	88,235	54	61.20	26	29.47
Tolland	29,954	7	23.37	9	30.05
Total	1,811,097	2,262	124.90	1,168	64.49

In Table No. 3 are tabulated cases of syphilis and gonorrhea according to population groups. In the towns under 5,000 will be noted the lowest case rate for syphilis. In the municipalities of 10,000-25,000 population the case rate for syphilis was slightly higher. In the population group, 5,000-10,000, the rate for syphilis was third highest. The highest case rate for syphilis was reported from the municipalities over 50,000 population, the rate being 192.35 The largest number of cases of gonorrhea was reported in the cities of over 50,000 population and the case rate remained high in this group. These data correspond to similar data in other sections of the country where the prevalence of venereal disease has been reported as higher in the urban areas than in rural areas.

In Table No. 4 the cases of syphilis and gonorrhea as well as the rates are tabulated as reported in cities of over 50,000 population. In 1939, New Haven had the highest syphilis rate which was 287.22. Hartford had the next highest rate which was 195.26. For the previous year 1938 the case rate for the city of Hartford was 297.71 as compared with a rate of 259.24 for New Haven. The city of Waterbury had the lowest gonorrheal case rate according to the reports received. The highest gonorrheal case rate was in the city of New Haven and was 160.50.

---

*Director, Bureau of Venereal Diseases, Connecticut State Department of Health.

TABLE 3—REPORT RATES BY POPULATION GROUPS — PER 100,00 POPULATION

		Syphilis		*Gonorrhea*	
Towns	*Population*	*Cases*	*Rate*	*Cases*	*Rate*
Under 5,000	199,945	116	58.02	66	33.01
5,000-10,000	156,539	120	76.66	46	29.39
10,000–25,000	230,373	140	60.77	91	39.50
25,000-50,000	465,711	427	91.69	215	46.17
Over 50,000	758,529	1,459	192.35	750	98.88
Total	1,811,097	2,262	124.90	1,168	64.49

TABLE 4—REPORT RATES TOWNS OVER 50,000 POPULATION—PER 100,000 POPULATION

		Syphilis		*Gonorrhea*	
Towns	*Population*	*Cases*	*Rate*	*Cases*	*Rate*
Hartford	187,957	367	195.26	261	138.86
New Haven	165,728	476	287.22	266	160.50
Stamford	71,833	146	203.25	44	61.25
Waterbury	107,300	127	118.36	43	40.07
New Britain	75,983	97	127.66	39	51.33
Bridgeport	149,728	246	164.30	97	64.78
Total	758,529	1,459	192.35	750	98.88

In Table No. 5 are tabulated cases and case rates for syphilis and gonorrhea of the cities in the 25,000-50,000 population group. The cases and case rates of the cities in this population group vary considerably. The highest case rates were found in Norwalk, New London and West Haven. Apparently in these cities the reporting is more adequate than for some of the other cities. The gonorrheal case rates of this group of cities were also varied but not to the extent of syphilis. The highest case rates for gonorrhea were in New London, Middletown and West Haven. It will be noted that in the city of Stratford no cases of gonorrhea were reported. This no doubt was due to inadequate reporting of this disease. It is safe to assume that there must have been some cases in a city of over 25,000 population.

In Table No. 6 will be noted a tabulation of syphilis and gonorrhea in municipalities in the 10,000-25,000 population group. The total syphilis case rate for this group was 60.77 compared with the total case rate of the larger cities as reported in Table 5 which was 91.69. The gonorrheal case rate in this group was 39.50 as compared with the rate of the larger cities found in Table 5 which was 46.17. It will be noted that no cases of either syphilis or gonorrhea were reported from Wethersfield during the entire year. Here again is an instance of inadequacy in reporting.

TABLE 5—REPORT RATES TOWNS 25,000-50,000 POPULATION—PER 100,000 POPULATION

		Syphilis		*Gonorrhea*	
Towns	*Population*	*Cases*	*Rate*	*Cases*	*Rate*
Meriden	43,063	17	39.48	25	58.05
West Haven	26,852	46	171.31	19	70.76
Hamden	29,807	12	40.26	9	30.19
West Hartford	39,510	14	35.43	5	12.66
Bristol	35,610	22	61.78	10	28.08
Manchester	25,229	12	47.56	12	47.56
Norwalk	43,331	128	295.40	18	41.54
Greenwich	42,876	38	88.63	23	53.64
Danbury	31,236	14	44.82	17	54.42
Stratford	25,400	6	23.62	—	—
Norwich	34,694	22	63.41	15	43.24
New London	33,312	68	204.13	28	84.05
Torrington	28,484	12	42.13	12	42.13
Middletown	26,307	16	60.82	22	83.63
Total	465,711	427	91.69	215	46.17

TABLE 6—REPORT RATES TOWNS 10,000-25,000 POPULATION — PER 100,000 POPULATION

		Syphilis		*Gonorrhea*	
Towns	*Population*	*Cases*	*Rate*	*Cases*	*Rate*
Ansonia	22,333	26	116.42	16	71.64
Wallingford	16,574	4	24.13	1	6.03
Milford	15,125	16	105.79	6	39.67
Naugatuck	14,615	5	34.21	4	27.37
Derby	11,288	9	79.73	6	53.15
East Haven	11,791	5	42.41	5	42.41
East Hartford	22,156	7	31.59	8	36.11
Enfield	14,921	12	80.42	1	6.70
Windsor	10,696	6	56.10	1	9.35
Wethersfield	10,370	—	—	—	—
Fairfield	22,398	14	62.51	9	40.18
Shelton	10,686	6	56.15	9	84.22
Groton	12,140	8	65.90	6	49.42
Stonington	11,737	11	93.72	10	87.93
Watertown	10,074	6	59.56	2	19.85
Windham	13,469	5	37.12	7	51.97
Total	230,373	140	60.77	91	39.50

In Table No. 7 will be noted the cases of syphilis reported by county according to stage of the disease. For 1939 there were 63 cases of primary syphilis reported. This corresponds to 87 reported for the previous year 1938. The cases of secondary syphilis numbered 145 for 1939 compared with 243 for the year 1938. As previously, many of the case reports did not state the stage of the disease.

TABLE 7—CASES OF SYPHILIS REPORTED BY STAGE OF DISEASE

County	*P.*	*S.*	*T.*	*C.*	*C.N.S.*	*N.S.*	*Total*
Hartford	19	59	293	47	4	161	583
New London	5	3	72	10	—	49	139
New Haven	16	39	443	56	30	189	773
Fairfield	15	34	282	72	9	232	644
Middlesex	5	3	15	4	—	5	32
Windham	2	4	10	2	—	12	30
Litchfield	1	2	39	4	2	6	54
Tolland	—	1	4	—	—	2	7
Total	63	145	1,158	195	45	656	2,262

P—Primary *T*—Tertiary *C.N.S.*—Central Nervous System
S—Secondary *C*—Congenital *N.S.*—Not Stated

In Table No. 8 cases of infectious syphilis, per cent of total, are tabulated for the eight counties. The total per cent of primary syphilis was 2.79 compared with a rate of 6.41 for secondary syphilis. The total per cent of infectious cases reported was 9.18 as compared with a total rate of 13.61 for the year 1938. This would seem to indicate that there was a slight decrease in the infectious cases. Further data from year to year will give better indication as to the trend.

TABLE 8—REPORTED CASES OF INFECTIOUS SYPHILIS — PER CENT OF TOTAL

	Primary		*Secondary*		*Total Infectious*	
County	*Cases*	*Per Cent*	*Cases*	*Per Cent*	*Cases*	*Per Cent*
Hartford	19	3.26	59	10.12	78	13.38
New London	5	3.60	3	2.16	8	5.76
New Haven	16	2.07	39	5.05	55	7.12
Fairfield	15	2.33	34	5.28	49	7.61
Middlesex	5	15.63	3	9.38	8	25.0
Windham	2	6.67	4	13.33	6	20.0
Litchfield	1	1.85	2	3.70	3	5.56
Tolland	—	—	1	14.29	1	14.29
Total	63	2.79	145	6.41	208	9.18

In Table No. 9 will be noted the cases of gonorrhea in the various counties reported by stage of disease. There were 854 cases of acute gonorrhea compared with 74 chronic cases. There were 6 cases of eye infections, two of which were ophthalmia neonatorum and the other four were eye infections occurring in children over thirteen days of age. A total of 227 case reports did not state the stage of the disease.

TABLE 9—CASES OF GONORRHEA REPORTED BY STAGE OF DISEASE

County	*A.*	*O.N.*	*G.V.*	*C.*	*Eye*	*N.S.*	*Total*
Hartford	310	1	—	16	—	33	360
New London	56	—	—	8	—	9	73
New Haven	288	1	3	37	1	86	416
Fairfield	132	—	3	9	2	89	235
Middlesex	28	—	—	2	—	2	32
Windham	14	—	—	1	—	2	17
Litchfield	19	—	1	1	1	4	26
Tolland	7	—	—	—	—	2	9
Total	854	2	7	74	4	227	1,168

A—Acute *G.V.*—Gonorrheal Vaginitis *N.S.*—Not Stated
O.N.—Ophthalmia Neonatorum *C.*—Chronic

It is trusted that physicians and health officers will bear in mind the importance of reporting all cases of syphilis and gonorrhea with the minimum information requested. By so doing it will be possible to give a more exact picture of the situation regarding the venereal diseases in Connecticut. In some of the towns the case reporting was low compared with other towns. This may be due to low prevalence in that particular town or may be due to inadequate reporting. It should also be emphasized that the data contained on the case reports are studied carefully so that the medical profession as well as the public will have, as they desire, a true picture of the reporting of cases of syphilis and gonorrhea in Connecticut.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief*,	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Stamford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

A PUBLIC HEALTH PROGRAM

It has been possible during the past few years, due to an allotment of Federal funds, to institute a very broad program of public health, especially in the fields of maternal and child health and also in the care and treatment of the crippled child. Although under the Social Security Act these funds are designated for specific purposes, nevertheless there is considerable latitude to allow for requirements arising in various communities. The State Department of Health has outlined how these funds can be distributed, and with the advice of the Public Health Committee of the State Medical Society, the program is functioning in a most efficient manner.

That part of our plan dealing with maternal health has already shown its benefits. It would be unfair to state that the low maternal mortality in Connecticut was due entirely to Federal help, and yet we can not overlook the fact that there has been a stimulation in interest in maternal health during the past few years, whether it is due to this Federal program or a combination of factors. One of the points emphasized has been a maternal mortality study on the basis of information submitted by a disinterested physician after consultation with the physician signing the death certificate. Considerable opposition has arisen on this point. No attempt has been made to demonstrate any lack of obstetrical judgment in these cases, but merely an effort to obtain a very detailed picture of the entire case for statistical purposes.

The part of the program dealing with crippled children is well under way and is functioning in a most effective manner insofar as the orthopedic cases are concerned, but when we consider that the definition of a crippled child in its broader sense includes not only the congenital deformities of the extremities and polio cases, but harelip, urogenital defects, rheumatic heart disease, deformities resulting from rickets, congenital heart disease and a host of other congenital and acquired defects which may interfere with the future education or employment of the child, then we realize that we have considerable work laid out in this phase of the plan.

While the two previously mentioned parts of the program are functioning in a rather efficient way, emphasis at present is being placed on the third part, namely, child health. Realizing as one does that this includes both the sick and well child throughout the state, one becomes impressed with the vast field covered in this section. An attempt is being made to give the physician opportunity for post-graduate training and, at the same time, adequate care of children, both sick and well.

To initiate, direct and carry on a program such as this, it is essential that well trained physicians be selected for the key positions. In the regulations from Washington, it is stated that the directors and consultants in these projects be diplomates of the various Boards in to which the particular case falls, or be eligible to that Board. It has been found that this is not possible in Connecticut if we are to complete a well-rounded program and it has been necessary in several instances, to draft men in certain sections not meeting Federal requirements in whom it seems advisable to entrust a responsibility which we feel they can well meet.

Here is an opportunity for every physician to contribute in some way to the success of this worth-while program. To date, results have been most encouraging and with the cooperation of the physicians of this state, Connecticut can maintain the high standard of health which we now enjoy.

J. H. H.

* * * *

THE PRESIDENT'S PLAN FOR NEW HOSPITALS

Only a few months ago lending his support to compulsory health insurance and to such legislation as the Wagner health bill, President Roosevelt has now openly declared himself possessed of a complete change of heart and in favor of the construction of fifty new hospitals instead of any plan for compulsory health insurance. The reasons for his sudden shift of purpose may never be made known but we suspect that the powerful influence of the Editor of the Journal of the American Medical Association has reached Presidential ears At all events, the drive for compulsory health insurance is bogging down. In a poll recently conducted by the Christian Science Monitor it was discovered that thirty-three members — more than one-third of the total number of the United States Senate are prepared to commit themselves against compulsory health insurance. As the Monitor says, "when any opposition movement starts with a nucleus of one third of the Senate members ready to pledge themselves, it would appear to be an insuperable bloc, unless or until conditions and circumstances alter basically."

But what of the plan for the construction of fifty new hospitals to be financed by a Congressional appropriation of $7,500,000 to $10,000,000? The President made this proposal on his birthday anniversary and one of his secretaries sentimentally called it "the President's contribution to the nation."

As the Editor of the Hartford Courant recently expressed himself, commenting on this proposal, "it costs very little to contribute an idea, but unfortunately its adoption may entail unexpected consequences." The same Editor is quite skeptical of the whole idea and warns Congress, that before it adopts the President's recommendation it ought to make very sure that the program, so attractively presented, is thoroughly practical.

During his address before the mid winter dinner meeting of the State Medical Society the dynamic Doctor Fishbein cited several instances where hospitals had been built by federal agencies at enormous costs, in isolated localities evidencing little if any need for any new hospital, and without any provision for maintenance. The $10,000,000 called for by the President would scarcely suffice to maintain these fifty new hospitals, this again must be left to the long suffering tax payer or the isolated philanthropist in that geographical sector who has managed to survive the frequent demands of taxation. Undoubtedly the entire proposal would be an experiment, as the President expressed it, "in the sense that the nation will gain much experience by undertaking such a project," but, like the Emergency Relief Administration and other projects of the New Deal, the cost of such an experiment would not be small.

Should Congress wish to appropriate $10,000,000 to hospital construction it would do better to place this sum where hospital facilities already exist and need increasing to meet local demands, reserving its construction program only for areas which can be proven to be in actual need of such construction and able to carry on the maintenance of new hospital facilities. It is one thing to build, as the President outlines, "simple functional structures, utilizing inexpensive materials and construction methods;" it is quite another problem to place these new buildings where local needs really exist, to staff them with physicians of the best type according to standards established by the American College of Physicians, the American College of Surgeons and the American Medical Association, and to maintain them in an economic and efficient manner.

* * * *

A FAMOUS FIRST

Medical bibliophiles, of which this state has its share, and all Connecticut physicians will be interested in a recent offering by a New York bookseller of a copy of "Cases and Observations by the Medical Society of New Haven County, Conn." It is described as an "utmost rarity" and the price seems fantastic. It was the first volume of medical papers in America. The exact date of publication is not known but a motion to publish them was passed by the members of the New Haven County Medical Society on January 2, 1788, on the title page is "Printed by J. Meigs, 1788" and the prefatory note, which was probably written by Samuel Darling, the clerk of the Society, is dated June 14, 1788. The pamphlets were available for distribution at the meeting of July 2, 1788, and seventeen copies were sold at that time. The price was one shilling and sixpence. Later Mr. Robert Hodge of Boston bought fifty copies. It has been stated that five hundred copies were printed, but this has not been substantiated. Fortunate indeed is the collector who can cherish in his strong box this precious item of medical Americana. Of it Riesman said in his Shattuck Lecture, "As a strictly medical contribution the honor of priority belongs to 'Cases and Observations by the Medical Society of New Haven.' This is a collection of 26 articles by physicians, of which one is of outstanding historic importance, for it represents the first original contribution to nosography by an American physician. I refer to an article on congenital hypertrophic stenosis of the pylorus by Hezekiah Beardsley. . . The honor of discovering this disease has been claimed for other men; for example, for George Armstrong, who in a book entitled 'Essay on Diseases Most Fatal to Infants.'. . (London 1771) describes the case of a child about 3 weeks old who died of 'watery gripes' and in whose stomach Armstrong found the pylorus to be firm. It is probable that this was a case of congenital hypertrophic stenosis of the pylorus, but Armstrong's description does not compare with that of Beardsley."

The little volume was completely reproduced in photographic fac-simile with an explanatory and descriptive note by Dr. George Blumer in the January, 1934, issue of the Yale Journal of Biology and Medicine at the time of the 150th anniversary of the founding of the New Haven County Medical Association.

C. B.

* * * *

THE GREATEST OF ALL GIFTS

During the past month a small folder entitled "Priceless Heritage" has gone out to all physicians in the United States. If you have not read it you should. Within this booklet will be found this sentence: "This greatest of all gifts — the advantage that belongs almost exclusively to the American people is: 'The right to think without restraint and to voice thoughts with words without limitation or restriction.' " This priceless heritage was guaranteed in the Bill of Rights of the American Constitution.

Socialized medicine, appearing on the horizon, is not just a menace to good medical care but is an evidence of a political trend, an evidence of centralization of power in the hands of a few. The removal of all incentive to individual ambition, the increase in public instrumentalities better known as bureaucracies, the publishing of the gospel of dependence on a federal government — all these retard progress, banish freedom, destroy the zeal for research. Americans do not want this. There is no better reason for opposing socialized medicine.

The National Physician's Committee for the Extension of Medical Service has two aims; (1) Making possible the providing of medical service to the indigent and those in the low income groups, and securing the most widespread distribution of the most effective methods and equipment in medicine and surgery; and (2) countering destructive propaganda by familiarizing the public with the facts in connection with the methods and achievements of American

Medicine. The work of the Committee is maintained exclusively by voluntary contributions. It is a vital program and merits your whole hearted support. The right to think without restraint is the priceless heritage of the American people.

* * * *

OUR YOUNGER BROTHER

The Connecticut State Medical Journal no longer remains the youngest member of the family of state medical journals. In January of this year appeared the North Carolina Medical Journal, the official organ of the Medical Society of the State of North Carolina. As in our own case this new journal replaces the Annual Proceedings of that particular Society. The Editor, Doctor Wingate M. Johnson of Winston-Salem, has already become known as a writer for lay publications, his productions not being confined to medical subjects. We extend a hearty welcome to the North Carolina Medical Journal, to Doctor Johnson and to his editorial board. We covet for this new journal a long life of usefulness to its Society.

1940 ANNUAL MEETING

Arrangements for the forthcoming meeting of the Connecticut State Medical Society are nearing completion. The program for the Scientific Session involves two new principles. In the first place, the panel of eminent visitors will be given more time for discussion and the discussion will not be confined to the subjects brought out by the essays but will be pertinent to the subject of the day and ample time will be allowed for questions from the floor. The second new feature consists of a cooperative scheme between the Program Committee and the Program Chairman of the several sections, the idea being that subjects bearing on the main theme of the day will be discussed in the section programs and the panel speakers will be available in some of the sections, if desired, to continue a discussion of questions brought out in the morning. The Program Committee hopes that their decision to discuss one system at a time, instead of a number of short and widely different subjects, will prove of benefit and it is to be hoped that the section programs in connection with the annual meeting of the State Society will be of interest and practical value to the body of the membership and not confined to specialists in the several fields. On this page of the Journal appears the preliminary outline of the program so far arranged. Suggestions for questions to be submitted to the panel and discussion of other phases of Cardio-Reno-Vascular Disease and Castro-Enterology would be welcomed by the Editor of the Journal, the Chairman of the Program Committee and the Executive Secretary. In succeeding issues of the Journal, a detailed description of the speakers and the topics for discussion at the section meetings will appear.

A. N. Creadick, M.D.
Chairman Program Committee

Wednesday, May 22

Ballroom
9:30
Doctor Linde, Presiding
General Subject: Cardio-Reno-Vascular Picture

Panel: Paul D. White, Boston
William S. McCann, Rochester
James C. White, Boston
Foster Kellogg, Boston

9:30 Walls Bunnell, Farmington
Louis H. Nahum, New Haven
John Wentworth, Hartford
William Bruckner, New Haven
to *Recess*
Edwin F. Gildea, New Haven
Clarence G. Darrow, New Haven
11:30 Lee E. Farr, New York

11:30 Discussion by Panel
to and
1:30 Question Period

1:30
Luncheon
2:30
Section Meetings
Orthopedics
Pediatrics
Anesthesia
Industrial Hygiene
Dermatology and Syphilology
Women's Medical Society
Medical Record Librarians
Connecticut Hospital Association
7:00
Cocktail Hour
7:30
Annual Dinner
Speaker to be announced

Thursday, May 23
Ballroom
9:30
Doctor Creadick, Presiding
General Subject: Gastro-Enterology
Panel: T. Grier Miller, Philadelphia
Louis E. Phaneuf, Boston
George P. Muller, Philadelphia
Albert D. Rudemann, Cleveland
9:30 Benjamin White, Hartford
George A. Gosselin, Hartford
James C. Fox, Jr., New Haven
Shirley H. Baron, New London
Ashley W. Oughterson, New Haven
to *Recess*
Samuel D. Kushlan, New Haven
Simon Kleiner, New Haven
Floyd Weed, Torrington
11:30 Arthur H. Morse, New Haven

11:30 Discussion by Panel
to and
1:30 Question Period
1:30
President's Luncheon
3:30
Section Meetings
Proctology
Radiology
Physiotherapy
Eye, Ear, Nose & Throat
Neurology and Psychiatry
Obstetrics and Gynecology
Occupational Therapy Society
Connecticut Branch, American Association
Medical Social Workers

☆☆

NEW ENGLAND HEALTH INSTITUTE

The prelimianry announcement for the New England Health Institute has been received. The Institute will be held in Hartford this year on April 15-19, with headquarters at the Hotel Bond. In the Schedule of Courses are found the names of Doctor Charles L. Larkin, Chairman of Cancer, Doctor David R. Lyman, Chairman of Tuberculosis, and Doctor Eugen Kahn, Chairman of Mental Hygiene. A registration fee of one dollar will be charged to cover routine expenses.

☆☆

MEDICAL SOCIETY MEMBERS IN CHICAGO

Doctor Thomas P. Murdock, Secretary of the Medical Examining Board of Connecticut, attended the 36th Annual Congress on Medical Education and Licensure at Chicago on February 12 and 13. The Executive Secretary, Doctor Barker, presented a paper on medical surveys before the National Conference on Medical Service at the Palmer House in Chicago on February 11. At the same time Doctor Wilmar Allen, Director of the Hartford Hospital, was in Chicago attending the Council meetings of the American Hospital Association. Mr. James A. Hamilton, Superintendent of New Haven Hospital, also attended these meetings.

☆☆

THE SPEAKER'S BUREAU IS ACTIVE

On February 21, Doctor James R. Miller of Hartford spoke before the Kiwanis Club of Waterbury on the National Health Program. Doctor Creighton Barker, Executive Secretary, addressed the Men's Forum of Litchfield on the National Government in Medicine on February 1 and the Norwich Rotary Club on the same subject on February 28.

☆☆

NOT ENOUGH VITAMIN B_1

George R. Cogwill, Ph. D., of Yale University has made known in a report recently authorized by the Council on Foods of the American Medical Association that the American dietary is low if not deficient in vitamin B_1 or thiamin. In addition to causing beriberi and other forms of nervous disease, the lack of this vitamin may manifest itself in loss of appetite and in limiting the growth of children. Its deficiency has been brought about by the great consumption in the American diet of highly milled cereal grains and refined sugar.

The PROFESSIONAL EQUIPMENT Co. EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

From the Secretary's Office

CREIGHTON BARKER, M.D.
258 Church Street New Haven

SOCIETY ACTIVITIES

Committee on Prepaid Medical Service

This Committee, under the Chairmanship of Doctor Samuel C. Harvey, met on January 8. There were present Doctors Griffin, Harvey, Murdock, Stringfield, and Barker. Plans are being furthered for conferences with representatives of the public.

Clinical Congress Program Committee

The Program Committee for the Clinical Congress, of which Doctor L. H. Nahum is Chairman, met at the Yale Medical School on January 19. There were present Doctors Bayne-Jones, John Mendillo, Nahum, Sanford, Strauss, Vestal and Barker. Doctor Thoms, the Secretary of the Congress, was detained by illness. Preliminary plans were made for the program for the 1940 Clinical Congress.

Committe on Industrial Medicine

This Committee was again entertained at dinner by Doctor Cole Gibson at Undercliff, Meriden, on January 23. Present were Doctors Gibson, Gray, Kuh, the Chairman; Richard Shea, Vestal, Whipple and Barker. Doctor Kuh and Doctor Gray reported the transactions of the Council on Industrial Medicine conference in Chicago and the agenda of the Committee for 1940 was discussed. It is proposed to have an organization meeting for a Section on Industrial Medicine at the Annual Meeting of the Society in May.

Mid-Winter Dinner Broadcast

During Doctor Fishbein's visit to Hartford on January 25 he broadcast on a blue network hookup over WTIC and his address before the Society was also broadcast over WTHT. Arrangements for these radio programs were made by Doctor Locke of the Society's Committee on Public Relations.

Program Committee and Committee on Arrangements for Annual Meeting

These two Committees met jointly with the Chairman and Secretaries of the various special Sections at the Hunt Memorial on January 25 preceding the mid-winter dinner. The meeting was presided over by Doctor A. N. Creadick, the Chairman of the Program Committee, and final plans for the Annual Meeting Program were developed. Doctor Thatcher W. Worthen is the Chairman of the local Committee on Arrangements for the Annual Meeting.

Committee to Study Osteopathic Legislation

Doctor Parmelee, the Chairman of the Committee to study Osteopathic Legislation, called the Committee together for its first meeting at the Society's offices on January 31. The entire Committee was present: Doctors Flynn, Oberg, Parmelee and Barker. During the months since the Committee was appointed a large amount of material has been collected by the Secretary and Doctor Flynn which is now being studied by the Committee.

Committee on School Health Policies of the State Department of Education

This interesting conference group held its first meeting of the new year in New Haven on February 5, and continued its discussion and formulation of medical and dental programs for public schools.

Representatives of the Society who attended this conference were Doctors Linde, Stringfield, Charles Wilson and the Secretary of the Society.

Technical Exhibit at the Annual Meeting

Doctor John H. Bumstead, the Director of the Technical Exhibit which will be held with the Annual Meeting in Hartford in May, has announced that all of the spaces available have been taken by commercial exhibitors. The exhibit will be held in the ballroom at the Hotel Bond, which by some ingenious feat of engineering Doctor Bumstead proposes to divide in two with a soundproof partition. Twenty firms will be represented, some of which have been with us for a number of years and a few new ones. It is pleasant to welcome the Arlington Chemical Company and Nestle's Milk Products, Inc.

The Arlington Chemical Co.	Yonkers
R. B. Davis Co.	Hoboken
Davies, Rose & Co.	Boston
The Doho Chemical Co.	New York
Eisle and Company	Nashville
C. B. Fleet Company	Lynchburg
Horlicks Malted Milk Corp.	Racine
Jones Metabolism Equipment Co.	New York
Lederle Laboratories, Inc.	New York
E. F. Mahady Company	Boston
Mead Johnson & Company	Evansville
Nestle's Milk Products, Inc.	New York
Petrolagar Laboratories, Inc.	Chicago
Surgeons & Physicians Supply Co.	Boston
Professional Equipment Company	New Haven
Scientific Sugars Company	Columbus
Smith, Kline & French Laboratories	Philadelphia
The D. G. Stoughton Company	Hartford
The Sun Rayed Company	Frankfort
E. L. Washburn & Company, Inc.	New Haven

The returns from the questionnaire sent out after the Annual Meeting in 1939 showed widespread interest in the exhibit of medical books and an especial effort has been made this year to attract publishers, but apparently they have a feeling that the book market in Connecticut is so good that they do not have to exploit their wares, for up to the present it has not been possible to have a bookman take space.

☆☆

FIFTEENTH JOINT MEETING OF THE ASSOCIATION OF CONNECTICUT TUMOR CLINICS

Meriden Hospital, Meriden, Conn.
Thursday, March 7, 1940, at four o'clock

PROGRAM

1. GYNECOLOGICAL CASES
    a. Review of Cases of Carcinoma of the Ovary — E. W. Foster, M.D.
    b. Sarcoma of the Uterus — 3 cases — Averill Liebow, M.D.
2. CARE OF INOPERABLE CANCER
    a. The Medical Viewpoint — T. P. Murdock, M.D.
    b. What the Neurological Surgeon can Offer — Max Taffel, M. D.
3. CRYMOTHERAPY
    Presentation of Apparatus — D. P. Smith, M.D.,— L. A. Pierson, M.D.
    Discussion of Results — W. J. McFarland, M.D.

NATIONAL HOSPITAL ACT OF 1940

(Digest by Creighton Barker, M.D., Executive Secretary)

Senator Wagner of New York for himself and Senator George of Georgia introduced a bill (S.3230) before the Senate of the United States on February 1, entitled "A Bill to Promote the National Health and Welfare through Appropriation of Funds for the Construction of Hospitals."

The bill provides, Sec. 2, the sum of $10,000,000.00 for the fiscal year ending June 30, 1941, and such sums therafter as Congress may deem necessary for the purpose of assisting States, communities, health and welfare districts and other political sub-divisions of States in providing better health and medical services through the provision of needed hospital facilities to serve rural communities and economically depressed areas. The expenditure and control of the fund is to be in the Public Health Service.

Sec. 3 provides that States, communities and other political sub-divisions may make application to the Surgeon General of the Public Health Service. Such application shall contain information necessary to establish the existence of the need for hospitals and to give assurance acceptable to the Surgeon General that such hospitals will be made available under appropriate conditions to all groups of the population, will be maintained in good repair, and will be utilized in furnishing service of satisfactory quality.

A National Advisory Hospital Council is provided by Sec. 4 to consist of the Surgeon General and six members to be appointed by the Surgeon General with the approval of the Federal Security Administrator. The six appointed members shall be selected from leading medical or scientific authorities who are outstanding in matters pertaining to hospitals and other public health services. Term of appointment shall be for three years and members of the Council will receive $25.00 per day and actual expenses while engaged upon official business.

The National Advisory Hospital Council is authorized to advise the Surgeon General with reference to carrying out the purposes of the Act

a. by the review of applications for hospitals and the recommendation of such projects as in its opinion are needed,

b. the formulation of standards necessary to insure proper conduct of the hospitals,

c. formulation of rules and regulations to carry out the provisions of the Act,

d. review reports and inspections and when necessary the making of inspections with reference to personnel service and standards of maintenance of the hospitals.

The Surgeon General with the direction and counsel of the National Advisory Hospital Council is authorized to:

a. conduct, assist and foster studies and surveys of the needs of hospitals and the problem of hospital operation;

b. approve hospital projects and designate the location, type, equipment and size of hospitals and to allocate funds for their construction;

c. provide training instruction for personnel;

d. cooperate with State local health and welfare authorities and with professionala gencies;

e. secure reports and make inspections with respect to service rendered and standards maintained in hospitals;

f. lease hospital projects to the applicants for an indefinite period, the consideration for such lease being the maintenance and operation of State hospitals in accordance with the Act. If at anytime maintenance and operation by the applicant shall fail to meet the standards provided, the lease shall be terminated by the Surgeon General on six months notice.

Sec. 7 of the bill provides that when a hospital project has been approved by the Surgeon General with the advice of the National Advisory Hospital Council it shall be certified by the Federal Security Administrator to the Federal Works Agency for construction and there shall be allocated and transferred to the Federal Works Agency so much of the appropriation as may be determined to be available for the project and the Federal Works Agency will expend such sums for the planning, execution and construction of the project including administrative expenses, acquisition of the site and preparation of drawings and specifications, and award all contracts and supervise construction and expend such sums as may be necessary for the completion of the project. Title to the properties and the equipment installed therein and the land upon which they are located shall be vested in the United States. The Federal Security Administrator is authorized to accept on the behalf of the United States gifts of money, equipment and land to aid in the carrying out of the purposes of the Act.

The Act also provides in Sec. 10 for the addition to the Public Health Service of commissioned officers and such other personnel as may be necessary to carry out the provisions of the Act.

The term hospital is used in the Act to include physical facilities necessary for the prevention, diagnosis and treatment of disease and for the protection of the public health.

COMMENT: This bill provides an *appropriation* of $10,000,000.00 for the *construction* of hospital facilities, the *allocation* and extent of which are determined by the Surgeon General of the Public Health Service in *consultation* with a council appointed by the Federal Security Administrator. The hospitals are to be *planned* and *built* by the Federal Works Agency and *title* to the hospitals is to remain with the federal government. The hospitals are to be *leased* to local agencies for *maintenance* and management under such regulations as are provided by federal authority and if these regulations are violated the leases may be *terminated* by the federal government upon six months notice. (The bill does not state what will then happen to the hospitals). It appears that close supervision by the Public Health Service is contemplated by the Public Health Service since the bill provides for the extension of the personnel of the Public Health Service for this purpose.

The PROFESSIONAL EQUIPMENT Co. X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS. TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

Connecticut Hospital Association

MARCH 7th — 9th

This is the date of the New England Hospital Association meeting to be held at the Hotel Statler in Boston.

It is always a most interesting meeting and is thoroughly enjoyed by everyone.

Make your hotel reservations now.

* * * *

THE NEW ENGLAND INSTITUTE FOR HOSPITAL ADMINISTRATORS

The Advisory Committee has set the date as Sept. 1 to Sept 15 for the first New England Institute.

The enrollment will probably be limited to 100 with the attendance prorated so that each of the New England states may have a proportional representation.

This movement should have the hearty support of our Connecticut hospital administrators.

* * * *

THE HOSPITAL INSTITUTE

An Institute may be defined as a refresher course in the field of hospital administration. It is usually of two weeks' duration, conducted at a university and designed primarily to keep administrators professionally fit. Such a course is offered under the guidance of hospital administrators and is offered exclusively to those who are actively engaged in the management of institutions.

The institute consists of three distinctive types of instruction: (1) lectures by recognized hospital administrators and professionally qualified specialists; (2) field trips to a number of hospitals in the metropolitan area in which the institutes are offered; and (3) panel discussions, usually held in the evening under the chairmanship of an administrator qualified to discuss the designated subject.

The hospitals used in the field trips are carefully selected and the departments that offer the presentations to the administrators are carefully instructed not to present wordy descriptions of operations or merely to guide the visiting group through the departments for an observation of the equipment and facilities. Rather, the hospitals are requested to give demonstrations that really are demonstrations in the true sense of the work. Action is the keynote, with a verbal account of the department's or division's activities as a supplement to the visual presentation.

Panel Discussions Popular

The panel discussions provide an opportunity to coordinate the lectures and field work with the actual problems of the administrator and serve as a clearing house for the full and intelligent discussion of the problems that seem most urgent to the administrators in attendance. Incidentally, they provide an excellent opportunity for those planning national and state hospital associations meeting to sense the more vital issues confronting administrators at any one time and thus to aid in the planning of subsequent conventions and meetings.

The type of instruction at the institutes is different from that given at conventions in which speakers are brought to address the group for from fifteen minutes to half an hour. The institute provides for a fuller and more complete discussion of a subject, usually over a period of two hours, on consecutive days. This longer time period allows for ample discussion by the student body of the subject matter presented and of the particular problems of individual students.

Individual and Group Conferences

New developments and new aspects of the student-teacher relationship have also been experimented upon. Arrangements have been made for special individual or group conferences with guest lecturers and outstanding administrators in the community so that students have the opportunity to discuss their problems fully and independently with outstanding authorities.

* * * *

OXYGEN THERAPY IN THE SMALLER HOSPITAL

Recently in one of our local factories a worker suddenly fell to the floor, unconscious. The police and one of our resident physicians arrived and began giving artificial respiration and treatment with the inhalator, slowly bringing the man back to life. When it was deemed safe to move him to the hospital, the physician telephoned ahead to order an oxygen tent ready for use. Our oxygen technician saw the patient brought in with the inhalator mask still in place and oxygen being administered. The technician called for one of our emergency masks and substituted this for the inhalator, continuing to give the patient pure oxygen mixed with the patient's own carbon dioxide. The tent was not used until after the patient was free of all danger of immediate respiratory collapse.

The patient made an uneventful recovery from the cerebral hemorrhage that had overcome him and owes his life to the splendid efforts of our house physician who had worked over him when all hope seemed gone.

The advantage of not placing the patient in an oxygen tent when he arrived at the hospital was explained by the technician. The patient being treated with an inhalator was getting a mixture of 93 per cent oxygen and 7 per cent carbon dioxide which is added as a stimulant to the respiratory system. Had this been taken away and an oxygen tent substituted the patient would have received only air until the tent filled and then at best only about 65 per cent oxygen. That change might have been too much for his badly deranged breathing apparatus. This incident offers a striking example of the improved service that can be given to patients in one department which is too often overlooked or neglected in many hospitals today.

(Introduction of article by Mr. Fred Loase of Greenwich Hospital appearing in Hospitals, Jan. 1940.)

* * * *

FREE CARE

It has often been pointed out that actually there is no such thing as free hospital service; the cost of caring for indigent patients must be borne by philanthropy, return on invested funds or patient's income. It is feared that a considerable portion of the population are under the impression that they can fall back on the hospital and expect to get something for nothing, with no realization of the fact that somehow, somewhere the cost must be met; others may sense the hospital's position but are in the class recently referred to as the "something-for-nothing addicts." It is to be expected, therefore, that almost any form of national legislation affecting hospitalization will make a strong appeal to the masses. The explanation can be found in their reliance upon "the government" as some superforce that can meet their needs and create purchasing power. They reason: "We can't, or should not, pay for modern hospital protection as individuals — so why not let the government provide it for us." They do not stop to think that the government has nothing but what it takes away from the people who are citizens. Similarly — the hospital has nothing but what it receives from its services, augumented by philanthropy.

Hosp. Dig., Dec. 1939

* * * *

PROGRESS AT THE NORWALK HOSPITAL

Additions to the Norwalk Hospital costing approximately $25,000.00 were opened in February. These consist of enlarged interns' quarters to comfortably house eight interns and three additional rooms added to the roof solarium so as to make possible efficient nursing of maternity patients on that floor. A nursery with a capacity of twelve bassinettes, a utility room and a good sized storage room have been added. The additions improve the appearance of the hospital from the front and will slightly reduce overcrowding which in recent months has been a problem.

Within about a month active steps will be taken in the endeavor to raise $450,000.00 for a new maternity building which will be entirely apart from the existing hospital. This will be a maternity unit carefully designed to provide unusually attractive facilities and to permit the best possible technique. Studies during the last six months by obstetricians, pediatricians, architects, and consultants have demonstrated the wisdom of providing much more adequate facilities for the care of newborn babies than previously had been deemed necessary. Five separate nurseries will be provided. It is the belief of the architects and the Board of Directors of the hospital that the new accommodations will compare favorably with any in the New York metropolitan area or in the State of Connecticut.

November was the busiest month in the history of the hospital with an average of 166 patients daily. This compares with an average of 95 patients daily five years ago. The rapid growth of the hospital in that period and the forecast for the next few years makes expansion imperative at this time.

* * * *

IMPROVEMENTS AT THE DANBURY HOSPITAL

On December 27, 1939, the process of moving the equipment into the new addition at the Danbury Hospital was begun. The offices were transferred to their new location, and the laboratory, x-ray and operating room equipment were put in use. All this time the routine of the hospital was going on as usual.

The first floor is given over entirely to administration. The business office situated adjacent to the lobby, is in sharp contrast to the old office, because of its spaciousness, excellent lighting, and up to date equipment. A counter separates the business office from the main office.

The second floor is given over entirely to the x-ray and laboratory. The laboratory is set apart from the rest of the second floor by a glass paneled partition along the corridor. This arrangement was made to prevent the obnoxious odors which are peculiar to a scientific laboratory from penetrating the corridors. The x-ray department located on the opposite side boasts the latest in x-ray equipment and cannot be surpassed anywhere in Connecticut. For the first time in its history, the Danbury Hospital has equipment for deep therapy x-ray for the treatment of cancer, a phase of hospital care which Danburians formerly were obliged to seek out of town. Control rooms are encased in lead and the windows on either side, placed so that patients can be watched, are made of lead glass.

On the third floor there are fifteen private rooms. On one side of the corridor, the walls and rooms are done in pastel peach with pastel green chintz draperies. On the other side the color scheme is reversed. The equipment in all the rooms is maple of the latest type and planned entirely with the patient's comfort in mind. Each room has radio and telephone connection.

The operating rooms are located on the fourth floor. There are two major and two minor, all equipped in the modern manner, scrub rooms and sterilizing units between each room, the major rooms equipped with the Operay Multibeam Lights. The anesthesia, supply, doctors' locker and shower rooms are all located on this floor. The entire suite is done in pastel green tile with mosaic floors of matching tile.

The power plant, laundry, ice plant, water filters, paintshop and work shops are located in the basement. A clever bit of engineering took place, when several months ago the old power plant was disconnected and the new one put into operation. The change was made without causing any loss of power, heat or water supply to the hospital.

The kitchen, still in the process of construction, will be located on the ground floor.

In the meantime workmen are beginning alterations which will transform the old offices, laboratory, and x-ray space into wards. The old operating rooms will become four 4 bed wards.

Just as soon as the remodelling is completed a reception will be held, at which time all will be able to see the building.

* * * *

THE HISTORY OF THE WATERBURY HOSPITAL

Waterbury hospital is 50 years old.

During the half century a total of 117,837 patients were treated. That is more people than live in the city now.

Those and other interesting statistics were compiled in making up the annual report of the institution which, for many years, was the only hospital in the city.

At present, when advances in the treatment of disease and hospitalization have helped to make the public hospital-minded, it is somewhat startling to note that only 50 years ago Waterbury had no hospital at all. Those needing special care had to be taken to other cities.

The present elaborately equipped buildings and spacious grounds of the Waterbury hospital grew from an editorial which appeared in The Waterbury Republican on the morning of Sept. 1, 1882. It was written by J. Henry Morrow, at that time owner and editor of the paper. He said in his appeal for a hospital, "Those who will move in this matter and crystallize endeavor into fact will confer upon Waterbury a blessing of incalculable value and will hand down their names to the keeping of a grateful posterity."

General Assembly Granted Charter

Following the editorial suggestion, Frederick J. Kingsbury drew up an application for a charte which was introduced in the legislature by Rep. C. H. Carter at the January session in 1883. The charter was granted and approved March 14, but nothing was done until the close of the following year. Rev. Joseph Anderson, pastor of the First Congregational church, at the suggestion of Rev. Edmund Rowland, rector of St. John's, called a meeting of the Protestant and Catholic clergymen of the city to consider how best to cooperate with the corporators named in the Waterbury hospital charter. There was much eagerness to help but it required six years to raise adequate funds to provide and equip the institution.

Finally, on May 25, 1885, a committee of the board recommended "the homestead of A. B. Wilson consisting of about four acres of land with buildings and other improvements, better suited for the purpose of a hospital than any other available site." It further recommended that "measures should be adopted for securing the same by purchase."

Early Donations

Funds were still inadequate and it looked as if the purchase would have to be postponed when an unexpected gift of $25,000 from Erastus L. DeForest of Watertown brought about the realization of the long-cherished dream. The property, now Chase Park house and grounds, was attractively and admirably situated and, once purchased, plans advanced rapidly. The first appropriation from the state was $25,000 and was approved April 25, 1887. The first gift "constituting a perpetual fund for the support of free beds" was made by Dr. Henry Bronson of New Haven and accepted by the directors in 1889. The building was opened for public inspection Jan. 20, 1890, and the first patient admitted Jan. 28, 1890.

The first report that includes in the statistics the average length of stay per patient in the hospital is the ninth. That year 379 cases were admitted for a total of 13,178 days treatment, with an average of 32.5 days' hospitalization. For comparison, last year the hospital admitted 6,751 patients for whom 73,332 days treatment were given, and an average stay in the hospital of only 10.8 days.

Shorter Stays Needed

"There are several factors that have been active in shortening, by some 21 days, the period of hospital treatment required to restore the patient to a state of health permitting his return home, and in most cases to resume his normal life as a wage earner," said Dr. Henry Mason, present superintendent of the hospital. "Among these factors, first place must be given to experience greatly enriched through medical research, which allows today the application of the principles of scientific medicine on a much higher plane than was dreamed of 50 years ago. During this period the voluntary hospital field has demonstrated its importance by leadership, courage, and initiative as a potent factor in the advances made also in the fields of hygiene, sanitation, prophylaxis, nursing, and public education."

The executive committee in their 1899 report stated, "We have been unable as yet to obtain the necessary means to increase our facilities," and went on to mention the pressing need of more ward and operating space and a larger heating plant. Although they were able to enlarge somewhat the accommodations for patients, nurses and other operative needs, the Superintendent's Report, December, 1906, stated that "The present capacity has been tested to the utmost during the year and with an increasing business the lack of complete hospital conveniences is constantly felt."

Plan Better Hospital

It was about that time that the directors were able to purchase from Israel Holmes the land where the hospital is now located, and the next annual report of the executive committee states, "Some progress has been made in preparations for the new hospital. Recently Henry Bacon of New York has been engaged as architect and within a few weeks plans will be ready for inspection and estimate." The Holmes residence was moved some distance southwest and was used as a nurses' home. The corner stone of the new hospital was laid May 16, 1910, and the building was opened the following year. It had a capacity of 76 beds, and "all the other appointments of a complete hospital." The year the first unit of the Waterbury hospital on its present location was occupied, there appeared in the report of the executive committee the following sentence: "Through the continued generosity of friends of the hospital we think there will be no debt on the new property and that our former surplus will not be impaired."

With the growth of the city the work of the hospital and the pressure for hospital beds became so marked that the executive committee wrote in the 1917 report: "This work anticipating the requirements of a larger hospital leads to the announcement that our vice-president, Henry H. Peck, has commissioned Henry Bacon of New York to prepare plans for an addition to the present building, which will double the capacity of the hospital and provide a distribution of cases that will add much to the comfort of the sick — a great gift from a great-hearted man." The south wing of the hospital called "Peck Wing" was occupied during 1920.

During 1926 large surgical, labor and delivery suites were built on the fifth floor. The need for more accommodations for patients and also additional room for certain diagnostic and therapeutic equipment again became emphasized. Therefore, during 1927 a campaign to raise funds was successfully carried through and the new addition, north wing, with bed capacity for 150 patients and adequate x-ray, pathological and physiological laboratory space, was opened during 1929. That made the capacity of the hospital 340 beds including the nursery.

School of Nursing

While the hospital traces its origin back to the year 1890, the school of nursing was not organized until 1904 when the hospital was still located in the Wison home. It then consisted of some 50 beds. It was a brave beginning under conditions far from ideal, either from the point of view of construction or equipment, yet early workers inspired by the need devoted themselves untiringly to this project.

Until 1904 the nursing service had been done by graduate nurses. The first class of student nurses to enter numbered seven and by the end of the year their ranks had increased to 10. At this time only a grammar school education or its equivalent was required for entrance. A two year course was given with an optional third year if a student desired. Instruction was scanty as it was difficult to arrange for regular class work. Much of the knowledge was the result of learning after hard and bitter experience. Members of the staff generously gave of their time to assist with clinical teaching, while nursing was almost entirely taught by Miss Mary Andrews, then superintendent of nurses. At the end of three months before acceptance in the school students were examined in reading, spelling and arithmetic, as well as their accomplishment in nursing.

The hours of duty were long and tedious, students often working all day without relief. Periods of night duty were from 10 to 12 weeks long. Lectures were given during the students' short hours off duty or after 8 o'clock in the evening at the end of a busy day.

First Interne

These early days of the school were difficult and discouraging. Nurses carried many and heavy responsibilities along with their long hours, for it was not until 1911 that its first interne arrived, though for several years Dr. Engelke had served as a non-resident emergency officer. That year the hospital, having outgrown its original quarters, was moved to the new building on the estate known as Westwood. Due to the efforts of such leaders as Miss Andrews, Miss Archibald and others, together with a loyal student body and staff, and a sympathetic public, many changes for improvement were brought about.

As far back as the year 1907 an affiliation was established in obstetrics. Nurses were sent to New York for added experience in this particular branch of nursing. The home school is now able to give sufficient obstetrical experience to student nurses but affiliations are still maintained in order to make experience as broad and inclusive as possible.

In 1924 an affiliation was established with the Yale school of nursing for experience in communicable disease nursing and in 1936 an affiliation was established with Butler hospital in Providence for experience in psychiatric nursing. Full time instructors have been added to the staff, first one and then two; and with the continued growth of the school, the increase in the size of the hospital, and the consequent need for closer supervision, graduate head nurses and ward supervisors have appeared.

Since its beginning the educational requirements for entrance have steadily advanced from one year to two years to three years of high school, and in September of 1929 to high school graduation. In 1920 a four months' preliminary period was established. This preclinical term has since been developed into a five month period. The working day and night have gradually been decreased to 8 hours with an approximate 49 hour week.

The development of this school of nursing has not been unlike that of many others in the last 35 years, and those who have grown with it and helped to make it what it is have many fond memories of days spent on the wards and in the home. They have seen the hospital enlarge from one small building to a large structure with two spreading wings, the Peck Wing in 1918 and the north wing about 10 years later. They have seen the home in which they lived change and by one addition after another increase in size until even now it is not adequate. They have seen the school within the walls grow from 10 students in 1904 to one of the outstanding schools in the state, with a graduate staff numbering nearly 80 and a student body of approximately 100. Its graduates now numbering 424 are spread far and wide.

* * * *

WARTIME ECONOMIES

At the time of the World War, Mr. Oliver Bartine prepared this list of wartime economies. They were printed and had a wide distribution throughout the country. It is Mr. Bartine's belief, in which we should all share, that there is as much need of practicing these economies today as ever in hospital history. They are presented to our readers in the hope that they may be useful to all.

1. Cordial and loyal cooperation WITH and WITHIN all departments is absolutely essential.

2. All Physicians and Surgeons, visiting, attending, and house, as well as nurses and employees, are requested to bring about the economic use of drugs, dressings, appliances, and surgical supplies, as well as all food supplies.

3. DO NOT use an appliance or a surgical instrument, except for the purpose for which it is intended.

4. Save the worn out or broken article in order to obtain a new one on requisition.

5. Extravagance of the employees is frequently criticized within and without the Hospital. Help us to avoid this criticism.

6. Do not use electricity or gas when not necessary. To do so is wasting money. If you find an unnecessary light burning, turn it off. All lights not actually necessary must be extinguished by 9 p m.

7. Do not use the printed blanks of the Hospital for any purpose other than that for which they were designed. Blank forms cost money.

8. Old rubber is valuable. Do not throw any away. Keep rubber in a cool place. Do not allow any form of grease on rubber, as it causes it to rot.

9. Do not take the elevator to go up or down one or two flights of stairs.

10. Kindly cooperate in the economical use of linen.

11. China is very expensive. Observe the utmost caution in handling.

12. Any suggestions toward the economical use of supplies are solicited.

13. Extravagance in the use of food at the present time is CRIMINAL. Order only what is absolutely needed and return to the kitchen all unserved food.

14. Before making a requisition, assure yourself that it is ABSOLUTELY necessary.

15. Each ward or department must keep a strict account of all supplies.

16. Supplies are NOT to be taken from the Hospital.

17. Doctors, nurses, and attendants are directed to use the utmost economy in the use of gauze, cotton, bandages, etc. Do not use two pieces where one will serve the purpose.

18. Loss of time is wasteful and extravagant. For instance: To be late on duty often causes confusion and dissatisfaction. To be late at meals not only means delay in going on duty, but extra work in the dietary service and in other departments.

19. Handle all Hospital property and equipment with care. Our repair bill is already enormous.

20. Requests for repairs should be made by the head of the department on blanks provided for that purpose and sent to the Superintendent.

21. Heads of departments will please see that these orders are rigidly carried out.

22. If we all unite in small economies, it will make for a large economy for the Hospital as a whole.

23. "We have not had to do this before," is frequently heard. It should have been done before; now it is imperative.

* * * *

THE STATE MEDICAL SOCIETY CLINICAL CONFERENCES

One of the most interesting and instructive meetings held by the State Medical Society is the annual clinical conference. The broad scope of the subjects presented and the excellent presentation of every subject should make these conferences of interest to every physician in the State, and many of the papers would be of very real interest to hospital administrators. The Chairman of the Committee has asked the editor to urge all hospital administrators to keep these clinical conferences constantly in the minds of their staff members, and as the time approaches for the conferences to have each administrator do his utmost in securing the fullest attendance from among the physicians affiliated with his hospital. The editor also urges all hospital administrators to attend these conferences. More will be said on this subject later.

☆☆

HOSPITAL DISTRICTS FOR MENTAL PATIENTS

Since its opening in 1933, The Fairfield State Hospital at Newtown has functioned only as a "transfer" hospital, its patients having been previously committed, by regular Probate Court procedure, to either of the two other state hospitals for the care of the mentally ill, namely, Connecticut State Hospital and Norwich State Hospital. The decision as to which of these two hospitals a patient was to be admitted was left to the discretion of the committing Judge or physician.

In anticipation of the opening of new facilities at The Fairfield State Hospital, which would equip it to become a "receiving" hospital for newly committed patients, the need was felt for definite districts designating to which of the three state hospitals for the care of the mentally ill a patient from a particular community should be committed. The 1939 Legislature, therefore, enacted Section 572e of the Public Acts, 1939, providing that a State Board on Hospital Districts be created, districts to be established upon the basis of admission rates for the various towns and cities of the state and in such manner as to result in an approximately equal number of admissions to each of the hospitals. This Board consists of the superintendent, and one member of the Board of Trustees, of each of the three state hospitals, and is required to meet within the first two weeks of June and December of each year. In order to put the law into effect Governor Baldwin delegated Doctor Clifford D. Moore, Superintendent of The Fairfield State Hospital, as Acting Chairman to call the first meeting, which was held December 20, 1939. Doctor Moore was elected permanent Chairman, and Doctor Chester Waterman, Superintendent of Norwich State Hospital, Secretary. Others present were Mr. Robert Weir, Budget Director, representing Governor Baldwin; Doctor R. L. Leak, Superintendent, and Professor George Dutcher of the Board of Trustees, of Connecticut State Hospital; Mr. Kirk W. Dyer and Doctor Clements C. Fry representing the Board of Trustees of Norwich State Hospital and the Board of Trustees of The Fairfield State Hospital, respectively.

At this first meeting of the State Board on Hospital Districts, Doctor Moore reported that The Fairfield State Hospital was not as yet equipped to receive new admissions and would not be so equipped for at least another six months. There was some discussion as to whether, for the period until The Fairfield State Hospital should have proper facilities, the state should be divided into two districts, one for Connecticut State Hospital and one for Norwich State Hospital. It was decided that such districting should not be attempted and that commitments meanwhile may be made from any part of the state to either hospital, as formerly. The Secretary was instructed to release this decision to the press, and to notify the various committing courts, since the Act establishing the Board requires that information concerning such districting be made available to admitting and committing authorities, by letter or public notice or both. Doctor Leak and Doctor Waterman agreed to prepare and present at the next meeting of the Board, in June 1940, a record of the number of admissions to their respective hospitals for the past five years, divided as to towns. These statistics will be used as a basis for districting the state.

Since this Board is required by law to meet every six months districts may be altered as frequently to meet changing population conditions throughout the state.

SECTION ON Orthopedic Surgery

DEATH OF MR. NAUGHTON DUNN

In Birmingham, England, there died recently one of the outstanding orthopaedists of the world. Mr. Dunn gathered about him a group of young surgeons after the World War, that became one of the bright spots of England in the orthopaedic world. His contributions were sound and interesting up to his last few months. Just the month of his death he reported removing fragments of a comminuted olecranon, an unaccepted procedure by most surgeons though some day it may be quite the thing to do. The author of this section recalls a visit to his clinic with great pleasure. His associates will no doubt carry on his progressive work.

MEETING OF AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

January 21-25, dates of the meeting in Boston, saw many orthopaedic surgeons from Connecticut in attendance. Doctor Paul P. Swett of Hartford read perhaps the most interesting and thought provoking paper. Certainly it constituted one of the major contributions of the day concerning healing of bone tuberculosis. The papers, in general, were good and the meeting most successful. Boston always affords any group an ideal background of men and works for a scientific gathering.

STATE SOCIETY MEETING IN HARTFORD

The Secretary of the Section has called for members to submit papers for the annual meeting in May, to be held this year in Hartford. There are still time allowances for two more good papers. Please communicate at once with the Secretary your titles and needs concerning lanterns, etc.

NEWINGTON HOME FOR CRIPPLED CHILDREN

A residency will be vacant beginning July 1, 1940, at Newington Home for Crippled Children. There are 200 beds with every variety of children's orthopaedics available, affording an excellent one or two year residency, accepted by the American Board. Applicants may apply to Miss Constance Leigh, Superintendent, Newington, Connecticut, not later than June first.

TRACTION SPLINTS

Are your ambulances equipped with traction splints for emergency calls? Soon the State Police squad cars will be so equipped. Every time you call for an ambulance casually inquire whether they carry such equipment and know how to use it. This pressure will bring results beyond your realization. Such splints can be obtained at cost from the Secretary of the State Fracture Committee, R. M. Yergason, M.D., Hartford.

IDEAS

If you have any that you wish others to share, send them to this section, care of the Connecticut State Medical Journal, Hartford.

SECTION ON Proctology

The mid-winter meeting of the New York Proctologic Society was held at the Squibb Building in New York City on January 31. The program was as follows:

1. Slides of Perineal Anatomy
   R. V. Gorsch, M.D.
2. Analyzing the Diarrhea in Coloproctologic Disease. Dr. Martin S. Kleckner, President of the A.P.S. (by invitation)
3. Movies of the 1938 A. P. S. Convention
   A. W. Martin Marino, M.D.

The meeting was very well attended and the paper of the evening was followed by a very interesting discussion by several of the members present.

The Section on Proctology of the Connecticut State Society will meet on May 23 in Hartford. The speaker at the meeting will be Doctor George E. Brinkley of New York City and his subject will be announced at a later date. The members of the society may be assured that his address will be well worth hearing.

In addition to the afternoon meeting there will be a panel discussion on gastro-enterologic subjects in the morning, and it is felt that all members of the section should plan to be present for the morning meeting, as well as the afternoon session.

- The -
General Practitioner's Forum

The increasing use of lead in industry and agriculture poses the hazard of lead poisoning. Since economic necessity forestalls most attempts at preventive therapy, the problem has been to find an inhibitor of the toxic lead ion. Holmes and co-workers, J. Lab. and Clin. Med. Aug. 1939 offer Vitamin C-Ascorbic Acid as that factor. It forms a poorly ionized salt, lead ascorbate, with the toxic ion. This is absorbed by the liver and excreted with the bile. Personal experience with four cases has been very gratifying. Treatment used: high Vitamin C diet, 6 oz. fresh citrus juice every morning, 50 mg. tablet Ascorbic Acid at 3 P.M. and at bedtime. An odd fact uncovered in connection with this form of treatment: many old time painters chew tobacco, lemon or orange peel claiming that it is good for the colic. All are rich sources of the Vitamin.

* * * *

Robinson, Am. J. of Surgery, Jan. 1940, suggests the use of Ammonium Bi-carbonate in solutions of ½ of 1% up to 4%, for healing old sinuses, ulcers and infected wounds. He states that this chemical is the active factor in the maggot and allied therapies. It is inexpensive and solutions are easy to prepare. It certainly merits a trial.

* * * *

Two simplified treatments have been reproposed for Scabies. Parker, Lancet, 1939 1-987, emphasizes the treatment used in the Austrian Army during the World War. Technique: — Paint the whole body below the neck with a 40% solution of Sodium Thiosulfate, let it dry 15 minutes, then paint with 5% Hydrochloric Acid, let it dry 15 minutes, repeat the two procedures. The patient then puts on clean clothes. This constitutes a treatment. He claims that rarely are more than three treatments necessary. Curry, Canadian Pub. Health Jour. 30:294 1939, recommends Kissmeyer's treatment. Solution is made up of equal parts of soft soap, iso-propyl alcohol, benzyl benzoate. Technique: — patient sits in a warm bath and rubs self thoroughly with soft soap for ten minutes, then, while body is still wet, it is painted with the solution for five minutes, special attention is given to the affected parts; this is allowed to dry and the process repeated. Then the patient puts on the same clothing he wore before treatment and sleeps in the same bed clothing. After 24 hours a complete change of personal and bed clothing is made. One treatment is usually sufficient; however, to avoid reinfection, investigate all members of the family; launder, dry clean and air all personal and bed clothes; keep the hands and nails clean.

* * * *

The treatment of cryptorchidism-Froelich's syndrome-hypogonadism with Anterior Pituitary sex hormone is criticized by the Pediatric Surgeon. Objections are based on the following observations: — the majority of undescended testicles come down without treatment or with such simple treatment as diet and small amounts of thyroid extract; potentially harmful changes are induced in the epiphyses of the long bones; changes in the inguinal canal and around the testicle make later operation more difficult; it upsets the endocrine balance; congential hernias are often associated with the condition and need repair; it may induce torsion of the spermatic cord and the testicle.

They insist that if the treatment is used at all, it should be used in small doses over a trial period of one to three months at most. One result of hormonal treatment which has been overlooked is that these children are definitely benefitted physically by the increase in the size of the gonads.

As this subject is open to discussion, comments, pro or con, will be very welcome.

* * * *

Notes from the 'Old Doctor's Scrapbook'

Habitually poor posture and postural defects, by impeding proper drainage and promoting stasis, are responsible for many biliary and kidney conditions.

T. P. R., M.D.

Our Neighbors

MASSACHUSETTS

The annual report for 1938-1939 of the Dean of Harvard Medical School announces an interesting step in interfaculty cooperation. The Medical School Faculty have been discussing for some time the place of pharmacology in medical education and research. It has come to the conclusion that it is time for the formation of a new University Committee on Pharmacotherapy "With the purpose of encouraging cooperative undertakings between the various divisions of the University which are concerned with the far-reaching problems of the treatment and prevention of disease." The new committee includes professors of medicine, of pharmacology, of physiology, of biochemistry, of organic chemistry, and of biology drawn from the Faculties of Arts and Sciences and of Medicine. At present there is one member whose chief duty is to carry on research along lines formulated by the group; other investigators primarily attached to the joint enterprise will be added shortly. Plans are being formulated to arrange for the accommodation of advanced students interested in the field.

The comments of President Conant are worthy of note: "It is interesting to note that this recent example of a cooperative undertaking has come about because of the growing recognition of the interdependence in modern medicine of the pure and applied sciences. The techniques and skills of the different disciplines involved in the study of drugs and their action are now too complicated to be mastered by any one investigator; the knowledge is too vast to be assimilated by any one man. Only a group can furnish the collective ability required: the chemist transforming one drug to another, the pharmacologist studying its fundamental action on animals and men, and the clinical investigator bringing his knowledge of the actual problems of therapeutics — all these must join hands and pool their ideas if the advances in the future are to be worthy of those made in the past by individual pioneers."

Considerable objection apparently has arisen among the physicians of Boston to the establishment by a group of members of the Massachusetts Medical Society of Health Service, Inc., organized for the purpose of selling medical and surgical services on a yearly basis to any and all who may qualify and are able to pay the annual charge.

* * * *

NEW HAMPSHIRE

Former Governors Huntley M. and Roland H. Spaulding of New Hampshire have offered $200,000 for the construction of a new hospital at Rochester, N. H., provided the citizens of that city raise an additional $15,000 before March 15, 1940.

* * * *

NEW YORK

On January 21 the Department of Education and the Department of Health of New York State announced, among other new rules which had been adopted by the Board of Regents, a very important rule, No. 30, as follows: "No hypnotic or somnifacient drug intended for internal use shall be sold at retail or dispensed to any person except upon the written prescription of a physician, a dentist or a veterinarian, and the prescription shall remain on file in the pharmacy where compounded. Such prescription shall not be refilled if it bears indication by the physician, the dentist or the veterinarian that it is not to be refilled."

Doctor Peter Irving, a descendant of Washington Irving and Secretary of the Medical Society of the State of New York, was among the speakers at the luncheon held in Tarrytown in commemoration of the appearance of the portrait of Washington Irving on the new one cent stamps in the "Famous Americans" series. Mr. Farley sold the first sheet of the new stamps to Washington Irving, 3d, great-great-grandnephew of Rip Van Winkle's creator. (Mr. Farley might have kept better step with his fellow benefactors at Washington by *giving* this first sheet to the descendant of one who brought fame to his nation. — Ed.)

A seven year survey of the incidence of tuberculosis in New York City conducted by the City Health Department indicates that about 2.5% of the population is afflicted with the disease and that about 85% of those so afflicted are unaware of the fact. The highest percentage of tuberculosis — 5.3% — is to be found among the city's homeless men and the lowest among the college students — 0.2%.

* * * *

RHODE ISLAND

The Blue Cross hospital service plan anticipates a total enrollment of approximately 10,000 subscribers as it completes its first six months of operation in February.

One out of every six Rhode Island physicians was trained at Tufts College, according to its president, Leonard Carmichael.

The State Legislature has before it at the present time a proposed new Charter for the City of Providence. This Charter act stipulates that biennially the mayor shall appoint, subject to the approval of the council, a superintendent of health to serve until his successor shall have qualified. The Providence Medical Association would change the act to read "each six years the mayor shall appoint, subject to the approval of the council, a superintendent of health who shall be a doctor of medicine, and who shall have either a doctor's degree in public health or a minimum of five years' experience in the administration of public health, to serve until his successor shall have qualified. The qualifications for the position and the six year term are important changes which should be made in the act.

The State Registry of Motor Vehicles of Rhode Island now requires that ordinary motorists must have from 20-20 to 20-40 vision in their better eye with or without glasses. Persons having worse than 20-100 vision in their better eye will be refused licenses automatically. Taxicab drivers, bus drivers, school bus drivers or operators of jitneys or other public conveyances must meet more rigid qualifications.

- NEWS -
from County Associations

Fairfield

Numerous members of the Fairfield Medical Clan were seen at the mid-winter dinner of the State Society at the Hartford Club. Many favorable comments have been heard on Doctor Fishbein's rapid-fire talk. It is to be regretted that time did not allow him to tell of the work and attempts of various state and local medical groups to handle the problems of the day.

Another of the excellent series of talks on Infection was given before the Fairfield County Medical Association by Doctor Hugh Auchincloss, Clinical Professor of Surgery at the College of Physicians and Surgeons. The meeting, held at the University Club in Bridgeport on the sixth of February, was widely attended by physicians from all parts of the County. Doctor Auchincloss discussed the types of incisions for deep infection of the fingers, hand and forearm, and presented the case for midline or transverse incisions in the abdomen instead of the more common right rectus incision. He put in a plea for the use of smaller needles and smaller sutures and presented a remarkable display of delicate instruments and ingenious gadgets. Among the visitors who discussed his paper were Doctors D. Chester Brown and Stahl of Danbury.

The third annual Y.M.C.A. Health Week is under way in the Bridgeport area as this goes to press. Under the Chairmanship of Doctor J. Grady Booe, a program of forty old lay meetings has been arranged and will be addressed by physicians, dentists, and nurses. Emphasis this year is on Child Hygiene. This is a laudable effort to improve the health of the community by education in preventive medicine.

Doctor John J. Cloonan, attending surgeon of the Stamford Hospital, died in Stamford on the 28th of January.

* * * *

Hartford

Those who attended the regular meeting of the Hartford Medical Society on February 5, 1940, were well rewarded in hearing an interesting talk by Doctor George F. Cahill, Associate Professor of Urology of Columbia University, College of Physicians and Surgeons, New York, on "Urinary Obstruction." Doctor Cahill gave a review emphasized by black-board diagram of the physiology of the urinary tract. Following this he demonstrated by a large number of lantern slides, common and rare causes of obstruction.

Following this regular meeting of the Hartford Medical Society, a short session was devoted to a discussion relative to the continuance of the Surgical Section of the Society. No meetings had been held last year and it was found that opinion was somewhat divided but preponderantly for continuance of this valuable section. Consequently, it was finally voted to do so. A. W. Branon was elected President, Charles Mirabile, Secretary, and Louis Antupit was re-elected Treasurer.

At this same meeting the following were elected to active membership: M. Martin Gould, Daniel F. Harvey and John T. Winters. James Stretch was elected to associate membership.

Doctor Edward H. Crosby of Hartford has been certified by the American Board of Orthopedics.

The Annual meeting of the Interne Alumni of St. Francis Hospital, Hartford, will be held this year during the period of the sessions of the Connecticut State Medical Society in May.

There is a change in the programs of the Hartford Medical Society for next month. This concerns an exchange of dates. Doctor William Stroud will address the organization on the subject of "Gall Bladder Disease in Relation to Conditions of the Heart" on March 18, instead of on March 4 as originally scheduled. On March 4, however, there will be an interesting meeting by some of our own members on the subject of "Gastric Hemorrhage."

Doctor D. C. Y. Moore was recently honored by the Manchester Chamber of Commerce for his successful term of office as president of that organization.

* * * *

Middlesex

At a meeting of the Central Medical Society held February 12 the following officers were elected: Joseph A. Beauchemin, President, Philip E. Schwartz, Vice-President; Benjamin A. Roccapriore and Carl C. Chase were re-elected Secretary and Treasurer, respectively. The newly elected president gave a most interesting and instructive talk on the role the laboratory plays in crime detection.

Doctor Charles A. Russman, for several years senior physician at the Connecticut State Hospital in Middletown, has been promoted to the position of clinical director according to an announcement made by Doctor Roy L. Leak, superintendent of that institution.

Doctor Julius H. Grower has moved from his office suite on the fifth floor of the Middletown Savings Bank Building to a newly designed suite on the mezzanine floor. His new office occupies the space well known and formerly used as the Community Room.

* * * *

New Haven

Doctor Cyril N. H. Long, Sterling Professor of Physiological Chemistry at Yale University, addressed the annual meeting of the Greater New York Dietetic Association in New York City recently on "Recent Research on the Control of Metabolism by the Endocrine Glands." Doctor Long has received special recognition for his literature and lectures on the influence of the endocrine glands on metabolism.

Doctor Milton C. Winternitz, Sterling Professor of Pathology at the Yale School of Medicine, addressed an open meeting of the Rhode Island Society of Psychiatry and Neurology recently on "The Pathology of Arteriosclerosis."

The New England Journal of Medicine, February 8, 1940, contains a paper entitled, "Omentumectomy As a Safeguard Against the Recurrence of Omental Adhesions," by Charles L. Larkin, M.D., and Virginia G. Burnham, both of Waterbury. The discussion published with the paper is interesting.

* * * *

New London

Doctor Charles Kaufman, well known surgeon and Medical Examiner in New London, is convalescing in the Lawrence and Memorial Hospital from a severe attack of pneumonia. He is expected to leave the hospital within the next week. During Doctor Kaufman's illness, Doctor Edward Gipstein is acting as Medical Examiner.

February 1 at Uncas on the Thames the New London County Medical Association heard Doctor Catell and Doctor Hurxthal of Lahey Clinic give an interesting symposium on Thyroid Disease.

Doctor F. B. Hartman, young New London surgeon, is boasting a son, born January 5, 1940.

Doctor and Mrs. Roger Fowler of 5 Library Street, Mystic, are the proud parents of a baby girl, born February 4, 1940. Doctor Fowler started practice in Mystic in October, 1939. Not bad, eh?

Doctor Shirley Baron spent ten days in Miami, Florida, at the Annual Air Derby; he made the trip down and back by plane. Doctor Baron is, himself, an air anthusiast and is accumulating flying hours for a private pilot's license.

Doctor A. J. Leon of Mystic is again enjoying good health and practice after having spent some of the fall at the Lahey Clinic for a thyroid operation. This was followed by a short trip South.

Doctor E. G. Haliday of Stonington returned to his practice January 1 after a number of weeks forced absence following an operation for appendicitis.

Doctor and Mrs. Carl Wies are remodeling a home situated on the ocean at the mouth of the Thames river and commanding a beautiful marine view.

* * * *

Windham

Doctor and Mrs. E. J. Ottenheimer have recently returned from a two weeks' vacation spent in New York City and Florida.

The Windham Community Memorial Hospital, Inc., of Willimantic, Connecticut, under the will of Mrs. Louise Mason of this city is the recipient of a magnificent gift that will afford the Hospital a modern Nurses' Home and an endowment fund sufficiently large to maintain such a unit.

The estate consists mostly of cash, stocks and bonds, one large piece of real estate in Willimantic and two pieces of property in West Hartford. No actual figures of the total valuation of this gift were announced as the inventory of the assets has not been filed with the court but assurance is given that it is large enough to build a modern Nurses' Home of a dignified character that will meet all the Hospital needs of a graduate staff. The remainder of the funds is sufficient to maintain the Home in every respect.

The Hospital also announced a gift recently received of a Kelly-Kott Mobile X-Ray unit, the gift of Mr. William P. Jordan of this city, former President of the Institution.

Letters to the Editor

Ragweed — A Pest

To the Editor:—

During 1939 a definite campaign for ragweed elimination was carried through in Connecticut. The State Health Department and local departments aided very materially in this work. Some rather outstanding results have been accomplished. There are, however, in the minds of many people some definite thoughts about this ragweed and its relationship to hay fever. Some people are wondering if the medical men are united in the fact that hay fever and ragweed are relatively closely associated. In fact is ragweed responsible for hay fever? Many believe that it is the agency by which hay fever is increased in the individual. I am not a sufferer and I wondered about this matter myself, but in scientific work I also find that there is disagreement on several different points. I am wondering how the medical profession feels about this matter.

In addition I work with rural people largely, although part of my time is taken up by city people in their various garden clubs and in landscape gardening work and in other ways. I doubt from my contact, outside of the cities and larger towns, that we will ever be able to rid the countryside of ragweed. I am wondering if the medical field is united with me in this statement or disagree with me. I do feel that we can make our cities and larger towns practically 100% clean of this weed, provided that the medical profession is back of this movement. This includes the boards of health as well as doctors, and provided we can continue to carry on a program of education aided by city and town officials. This is really an open invitation for doctors or medical societies to express their point of view. To me this would be extremely valuable because I have much of the responsi-

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

bility of trying to do what I can from a statewide point of view on the eradication of this weed and any advice or assistance that can be given will be very welcome, in fact appreciated.

Professor Albert E. Wilkinson
Extension Specialist in Vegetable
and Landscape Gardening
University of Connecticut,
Storrs, Connecticut

* * * *

PROPOSED PLAN FOR NEW HOSPITALS

Toward the end of 1939, the State Department of Health received a communication from the Surgeon General of the United States Public Health Service, Thomas Parran, M.D., asking for certain data in regard to the need for additional hospitals in Connecticut, the data desired being in connection with a proposed tentative plan of The President's for the building of hospitals in localities where the deficiencies in such facilities are associated with limited economic resources.

The State Department of Health having no information available forwarded the letter to the office of the State Medical Society. Subsequently it seemed that the information desired could be obtained by having a joint meeting of the Board of Directors of the Connecticut Hospital Association and the Hospital Committee of the Connecticut State Medical Society.

The letter from Doctor Parran and the accompanying explanation of the tentative program follow:

Federal Security Agency
U. S. Public Health Service
Washington

December 29, 1939

Dr. Stanley H. Osborn,
State Commissioner of Health,
Hartford, Connecticut

Dear Doctor Osborn:

Your attention is invited to the attached statement of a tentative plan which the President is considering for the building of hospitals in localities where the deficiencies in such facilities are associated with limited economic resources.

In order that further understanding may be reached as to the nature and extent of the need for additional hospitals, especially to serve rural areas, I am requesting that you supply the best estimate that can be made on the basis of available information. This estimate should express the combined judgment of agencies concerned with the provision of hospital care. More specifically the data that would be helpful will include

1. The number of general hospitals which are needed in areas as described,
2. The aggregate number of beds,
3. The total population to be served,
4. The number of tuberculosis hospitals which are needed and the capacity of each.

Discussions with hospital experts have led to the conclusion that, except in very sparsely populated areas, it is uneconomical to construct and operate a hospital of less than 50-bed capacity. Furthermore it is our judgment, that ideally the community hospital should serve also as a health center for housing various public health activities of the area.

You will note that the President has suggested that the hospitals be built and equipped at federal expense but that no federal funds would be available for maintenance and care of patients. The operation of the hospitals will be a community or State responsibility.

Preliminary estimate of need should be placed in our hands not later than January 8, 1940. It is understood that such figures as you can supply may be subject to change in the light of more detailed study.

Sincerely yours,
Thomas Parran
Surgeon General

The hospital building program which the President has under consideration is tentative at the present time and relates to the construction by the Federal Government of hospitals and medical centers in communities of poor states which now lack them. The President has indicated his intention of recommending the plan to Congress after thorough study has been given it.

It is the suggestion that the hospital program be started modestly with fifty hospitals as the goal for the present. It is proposed that a committee of doctors advise the Public Health Service and select the localities applying for help where the need for the hospitals is greatest.

The plan provides that the Federal Government should pay all costs of construction and then turn the institutions over to *local groups* who gave assurances that they could manage them in a successful way from the standpoint of health and finances. Title to the buildings, however, would remain in the Federal Government.

The President has suggested a study of the matter with a view to immediate action rather than waiting for a complete and perfected plan for a health program such as that proposed in Wagner Bill. He has observed that those states which have the most wealth are able to put up the most money to get Federal aid and these states are the ones where health conditions are the best. Conversely the poor states are unable to match Federal grants and these are the ones where hospital facilities are most needed. There may be several hundred communities in need in the United States where this government might step in gradually to relieve the deficiency in hospitals. This may be called the first experimental step in bringing general medical health centers to places which lack them.

The money for the program, an estimate of which has not been given, would be made available to the Public Health Service with the idea that construction would proceed as on some of the buildings in recent programs in which as much W.P.A. labor as possible was used. At an average, the institutions contemplated probably will cost about $150,000 each and will have facilities for hospitalizing about 100 patients at a time. It would be the function of the United States Public Health Service to make plans and surveys and with the aid of an advisory committee of doctors to assume the responsibility of insuring efficient operation of the hospitals by the local groups.

A joint meeting of the two groups with the State Commissioner of Health was held on January 19, 1940, and the following motion was passed in regard to items 1, 2 and 3 of the Surgeon General's letter.

> Moved: that Doctor Osborn incorporate in his reply to Doctor Parran's letter the following statements:
>
> "It is the concensus of opinion of this joint committee composed of the Hospital Committee of the Connecticut State Medical Society and the Board of Directors of the Connecticut Hospital Association that as a tentative and preliminary statement the State of Connecticut does not need additional general hospitals because of the present wide and equable distribution of the hospitals in the state, but does need additional ward beds in urban community hospitals serving rural areas and it does need communicable disease beds in urban hospitals serving rural areas and it does need chronic beds throughout the State.
>
> "The population to be served are approximately as follows: Certain areas covering approximately a 600,000 population need additional beds in the existing institutions. In the rural areas totaling about 100,000 there is need for communicable disease beds. All of the State needs beds for chronic cases.
>
> "This opinion expressed above is just that of the committees and does not represent the opinion of either Association."

The members of the group present were: from the Board of Directors of the Connecticut Hospital Association, Chairman, Doctor Wilmar M. Allen, Messrs S. G. Davidson, O. H. Bartine, A. W. Buck, W. B. Sweeney, Miss A. P. Griffin: from the Hospital Committee of The Connecticut State Medical Society, Chairman, Doctor H. Bertram Lambert, Doctors H. B. Hanchett, F. N. Sperry, H. G. Jarvis, E. J. Ottenheimer, Creighton Barker, S. H. Osborn.

Item 4 in regard to tuberculosis hospital needs was taken up with the State Tuberculosis Commission, but information is not yet available.

☆☆

INDIANA STATE MEDICAL ASSOCIATION ADOPTS RESOLUTION ON PREPAREDNESS

The Indiana State Medical Association at its last annual meeting adopted a resolution constituting and empowering a committee "to act in liason with proper military and civic authorities and veterans' organizations to make a complete study for and prepare a detailed program for medical cooperation and preparedness in the event of M-day becoming a reality, to the end that in such an event an unhurried and effective program is established, supplying first: the medical needs of the military; second: the proper medical care at home during a military emergency."

SPECIAL NOTICES

AMERICAN BOARD OF INTERNAL MEDICINE, INC.

The American Board of Internal Medicine will conduct oral examinations just previous to the meeting of the American College of Physicians in Cleveland and just in advance of the meeting of the American Medical Association in New York City.

Applicants who have successfully passed the written examination and plan to take the oral examination in 1940, should advise the office of the Secretary at least six weeks in advance of the date of the examination they desire to take.

The next written examination for 1940 will be given on October 21st. Applications for this examination must be filed in the Secretary's office by September 1st.

Application forms may be obtained from Dr. William S. Middleton, Secretary-Treasurer, 1301 University Avenue, Madison, Wisconsin, U. S. A.

* * * *

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATIONS

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board at the Atlantic City Hospital, At-Atlantic City, N. J., from Friday, June 7, through Monday, June 10, 1940, prior to the opening of the annual meeting of the American Medical Association in New York City on Wednesday, June 12, 1940. Candidates are requested to note that the dates of the examinations have been advanced one day from those previously announced.

Application for admission to Group A, Part II, examinations must be on file in the *Secretary's Office not later than March* 15, 1940.

Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *reexamination* in Part II must make written application to the Secretary's Office before April 15.

The annual dinner of the Board will be held in New York City on Wednesday evening, June 12, 1940, at the Hotel McAlpin. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6) Pennsylvania.

* * * *

AMERICAN ASSOCIATION FOR THE STUDY OF GOITER

The next annual meeting of the American Association for the Study of Goiter will be held at Rochester, Minnesota, April 15-17, 1940. The program for the three day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics conducted by guests of the Association, and operative clinics conducted by the Staff of the Mayo Clinic.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held at Rochester, Minnesota, on April 15th, 16th and 17th, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the Corresponding Secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane, Pennsylvania not later than March 15th

The Committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays. Dr. T. L. Althausen of the University of California received the Award for the year 1939 in recognition of his essay entitled "A Study of the Influence of the Thyroid Gland on the Digestive Tract."

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

* * * *

THE NEW HAVEN MEDICAL ASSOCIATION RADIO BROADCAST SERIES — STATION WICC "EDUCATION IN HEALTH"

The New Haven Medical Association, in cooperation with the New Haven Department of Health and the Council of Social Agencies, is presenting a series of health talks for public education under the title of "Education in Health." These broadcasts are being given over Station WICC every Friday afternoon at 4:00 o'clock. The remainder of the program for March and April follows:

March	1	How is Your Skin?	Dr. M. J. Strauss
	8	Pioneers in Medicine	Dr. H. W. Haggard
	15	The Romance of the Heart	Dr. L. H. Nahum
	22	Cancer is Curable	Dr. W. C. Duffy
	29	The Story of Anesthesia	Dr. D. F. Levy
April	5	The Government in American Medicine	Dr. C. Barker
	12	Kidney and Bladder Symptoms	Dr. H. A. Levin
	19	Hard of Hearing	Dr. F. N. Sperry
	26	Common Surgical Emergencies	Dr. J. A. Gettings

AMERICAN ASSOCIATION OF OBSTETRICIANS GYNECOLOGISTS AND ABDOMINAL SURGEONS

1. "The award which shall be known as 'The Foundation Prize' shall consist of $150.00.

2. "Eligible contestants shall include only (a) interns, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M.D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal surgery."

3. "Manuscripts must be presented under a non-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the non-de-plume and containing a card"

4. "Manuscripts must be limited to 5000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis. Submit 3 copies of Thesis and illustrations to Secretary."

5. "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the Author's choice. Unsuccessful contributions will be returned promptly to their authors."

6. "All manuscripts entered in a given year must be in the hands of the Secretary before June 1st."

7. "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation."

8. "The President of the Association shall annually appoint a Committee on Award, which, under its own regulations shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

Jas. R. Bloss, M.D.,
Secretary,
418 Eleventh Street,
Huntington, W. Va.

* * * *

BOOKLIST FOR HOSPITAL LIBRARIES

Beginning in January 1940, the American Library Association will publish the *Booklist for Hospital Libraries*, new quarterly publication established to take the place of the *Hospital Booklist* which the American Hospital Assoclafion has published since 1936. The new list will also replace the semi-annual list of books for hospital use which has appeared in the A. L. A. *Booklist* for a number of years.

The *Booklist for Hospital Libraries* will be a cooperative undertaking of the hospital libraries committees of the A. L. A. and the A. H. A. and will be edited by Elizabeth Pieters. It will be mimeographed at first and the subscription price will be $1 a year.

Each issue will include reviews of about fifty carefully selected fiction and non-fiction titles. Annotations will tell for what types of patients in various classes of hospitals each book may be safely used — or not used. There will be occasional special articles, lists, and other information about books for those doing library work in all types of hospitals.

The *Booklist for Hospital Libraries* will be a helpful guide in the selection of books not only for the trained hospital librarian and the public librarian who provides hospital library service, but also for every librarian who seeks guidance in selecting books for invalid patrons, and for the untrained volunteers endeavoring to provide intelligent hospital library service.

Subscriptions should be sent to the American Library Association, 520 North Michigan Avnue, Chicago.

* * * *

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA

The Third South American Assemblies of the Interstate Postgraduate Medical Associations of North America, will take place from May 17 to July 23, 1940. South American countries to be visited are Brazil, Chile, Columbia, Uruguay, Peru, Panama, Argentina, Ecuador and Cuba. Early registration is of the greatest importance. For further information address W. B. Peck, M.D., Managing-Director, Freeport, Illinois, or Manager of Foreign Travel Department, American Express Company, 65 Broadway, New York City.

☆☆

COMING MEETINGS

March 4—8:30 p.m. Hartford Medical Society, Hunt Memorial Building. "Gastric Hemorrhage" — (speakers to be announced).

March 5—8:30 p.m. Bridgeport Medical Society, University Club. "Pneumonia" — Maxwell Finland, Boston, Massachusetts. Doctor Finland is Assistant Physician, Thorndyke Memorial Laboratories, Visiting Junior Physician, Boston City Hospital, and Assistant in Medicine, Harvard Medical School. *Note the change in speaker.*

March 12—8:30 p.m. Fairfield County Medical Association, Stamford Hospital. "Principles of Serological Treatment" — Russell L. Cecil, New York.

March 18—8:30 p.m. Hartford Medical Society, Hunt Memorial Building. "Gall Bladder Disease in Relation to Conditions of the Heart" — William Stroud.

May 14—8:30 p.m. Fairfield County Medical Association, Pickwick Arms, Greenwich. "Modern Trends in Chemotherapy" — Francis G. Blake, New Haven.

May 22-23—Annual Meetings: Connecticut State Medical Society (*see preliminary program in this issue*) and Connecticut Hospital Association, Hotel Bond, Hartford.

• OBITUARIES •

GEORGE WALLER HAWLEY, M.D.

1874-1940

George Waller Hawley died at his home in Westport, Connecticut, on New Year's Day at the age of sixty-five, following a ten years' affliction with tuberculosis. With his passing America lost a foremost Surgeon and Teacher. Doctor Hawley was born in Bridgeport and there received his early education. Later he attended St. Paul's School in Concord, N.H., and entered the Sheffield Scientific School of Yale University, graduating in 1896. He received his M.D. degree from Cornell Medical School in 1899, and interned at Bellevue Hospital for two years. Following this he spent a year in Vienna in postgraduate work. After returning to the United States he engaged in practice in the State of Washington, locating in a mining town near Seattle. There he substituted for several months for the mine physician. In this work he saw the rough side of life, and throughout his years of practice, probably having those days in mind, always gave freely of his services to those in unfortunate circumstances. For a time he practiced general surgery in Seattle, and was an intimate friend of the late Tate Mason.

In 1908 Doctor Hawley returned to Bridgeport and from then on devoted his time to Orthopedic Surgery. He began working with Doctor Virgil P. Gibney at the Hospital for Ruptured and Crippled in New York and continued on the staff of that hospital until his work in Bridgeport became so heavy that he had to discontinue his service. He also taught for some years at the Cornell Medical School and the Post Graduate Hospital.

It was in his early days at the Hospital for Ruptured and Crippled that he designed his first fracture table, the principle features of which were a top surface that could be lowered leaving the patient resting on supports to his shoulders and sacrum, and the extension arms that held the feet and made traction on the legs. This first table was a crude affair compared to the present Hawley table with its graceful lines and great efficiency. It was installed at St. Vincent's Hospital, Bridgeport, and an opportunity to test its usefulness on a real patient was eagerly awaited. Several weeks after the arrival of the table a youth of seventeen with a fractured femur was admitted, and the table was put into service. It proved to have all the advantages that its designer had visioned.

Doctor Hawley steadily improved on his table, and while in the Cragmore Sanitarium, Colorado, perfected the present model with features which made it adaptable for x-ray examinations. In spite of many imitators since the original table was brought out, the Hawley table has always held its leadership.

His most recent interest was in the angle bone plate originally advocated by the French surgeon Choutard, but neglected for years. Doctor Hawley felt that immobilization of the fractured bone and not the limb was the important feature of fracture treatment, and he felt that this could be best accomplished by the angle plate on account of its great strength. With the security obtained by this plate the use of plaster would be avoided and early motion could be carried out. After some work had been done on dogs at Yale School of Medicine it was apparent that his contention was correct.

The hurricane of 1938 provided an opportunity to try the plate on a patient. A man of thirty with a badly fractured humerus was admitted to the Bridgeport Hospital. Various splints and plaster failed to keep the fragments in satisfactory alignment, so a week after the injury was received the angle plate was applied with the result that the patient was actually back at work in five weeks, and at six weeks could hold a large dictionary on the outstretched hand. Doctor Hawley's faith in this type of plate will undoubtedly be more than justified, and he deserves great credit for bringing it to the attention of the surgical profession.

In his daily work as a surgeon Doctor Hawley showed that he had a fine analytical mind as well as a wide knowledge of his specialty. He was a master workman, handling tissues with delicate touch and carrying out a most meticulous technique. His inventiveness and ingenuity combined with surgical ability made him a great surgeon and his geniality and generous nature made him a fine friend.

During the World War Doctor Hawley spent about four months with the French Medical Corps before the United States entered the conflict. It was then that he worked with Carrel and learned the Carrel-Dakin method of wound treatment which he later introduced in Connecticut.

In 1917 he was commissioned a Captain in the U. S. Medical Corps and went to France with the New York Hospital Unit. In 1918 he was placed in command of Base Hospital Number Nine at Chateau Roux. For his work with the French he was decorated by the French Government and in recognition of his services at Base Hospital Number Nine his own country elevated him to the rank of Lieutenant Colonel. Returning to the United States in the Spring of 1919 he remained in the service for six months, working at the Reconstruction Hospital in New York. He was instrumental while there in having the brilliant Brazilian Surgeon, Doctor Chutro, hold several clinics. It was quite characteristic of him to welcome any suggestions, and he always had the deepest appreciation for the work of others.

In 1930 he was a member of the "Flying Clinic" that under the auspices of the Pan American Medical Congress made an aeroplane trip through the countries of Central America.

Shortly after his return from this trip he developed tuberculosis, and spent the next three years in Colorado. He came back to his home in Bridgeport in 1934, but never resumed his practice; however, his mind was ever active on surgical problems, and his interest in medicine was as acute as in earlier days. His full store of information and helpful advice was freely at the disposal of his colleagues.

In September, 1902, Doctor Hawley married Miss Anne Paine Murray of Chicago. His wife, a son, Murray, and a daughter, Mrs. Boris Lang survive him.

Louis Untermeyer must have had such men as Doctor Hawley in mind when he wrote that fine poem "A Prayer" — two stanzas of which I quote —

Ever insurgent let me be,
Keep me more daring than devout,
From sleek contentment keep me free,
And fill me with a buoyant doubt.

—

From compromise and things half done,
Keep me with stern and stubborn pride,
And when at last the fight is done,
God keep me still unsatisfied.

Daniel Patterson, M.D.

* * * *

ROBERT MILTON WOLFE, M.D.
1877-1939

Success in life does not mean the accumulation of wealth or the attainment of positions of honor or trust. True success, real success means service to fellowmen. The spirit of service to fellow man prompted Doctor Wolfe to choose medicine as a profession.

Doctor Robert Milton Wolfe was born in Hillburn, New York, Aug. 12, 1877, the son of Robert M. Wolfe and Margaret Carlough Wolfe. His father was a carpenter and builder by trade and was superintendent of the Ramapo Iron Works, Ramapo, New York. His early education was obtained in the Suffern Public Schools and his later training was obtained at the Stevens Institute of Technology, Hoboken, New Jersey and the University of Maryland, Baltimore, Maryland. While in college, he participated actively in athletics and developed a love of sports which he carried through life.

Following graduation from the University of Maryland, he took special training in diseases of infants and children at the Nursery and Childs hospital in Baltimore. On his entrance into practice he served as a physician during the small pox epidemic in Hillburn, N.Y. Shortly after this he entered practice in South Norwalk and he was practicing here but a short time when an epidemic of small pox occurred in this city. Because of his previous experience he volunteered for duty in the quarantine station established at that time. While on duty there, he met Miss Hannah B. Colbert, daughter of Mr. and Mrs. Timothy Colbert of Pittsfield, Mass. Miss Colbert was a graduate nurse from the New Haven Hospital and became his first wife. By this marriage he had two children, Robert M. Wolfe, an attorney and John D. Wolfe, physician. Mrs. Wolfe died in 1916 and Doctor Wolfe married Miss Mary L. Eike, daughter of Mr. and Mrs. George W. Eike of Stamford, Conn. By this marriage, he also had two children, Roberta M. Wolfe and Mona M. Wolfe.

Throughout his life Doctor Wolfe engaged in a very active practice and developed much of his energy and skill to the relief of the suffering of the poor. He also found time for much public service. He was Mayor of the City of Norwalk for two terms. He was a member of the City Council, member of the Public Board of Safety, Police Commissioner, Boxing Commissioner, Democratic State Central Committeeman. Fraternally he was a Mason and Past Exhalted Ruler of the Elks from 1902-03. His religious affiliations were with the Presbyterian Church. Doctor Wolfe possessed an excellent voice and was always interested in singing.

He passed away suddenly while on a shopping trip to New York on Sept. 26, 1939, from Coronary Thrombosis from which he had suffered intermittent attacks over a period of time.

Doctor Wolfe exemplified and typified the good family physician. He was not only the doctor of the family but the philosoper, counselor, guide and friend. He was a man with a remarkable disposition, kind, sympathetic and true. I never heard him say an unkind word about anybody.

William J. Tracey, M.D.

* * * *

JOHN JOSEPH CLOONAN, M.D.

1867-1940

On January 28, 1940, in The Stamford Hospital, Doctor John Joseph Cloonan died at the age of seventy-two, following an illness of several month's duration.

Born in Hartford, Connecticut, July 14, 1867, the son of the late Michael J. and Anna Tracy Cloonan, he received his preliminary education in the Hartford schools, in 1897 was graduated from the College of Physicians and Surgeons, Baltimore, and began his practice in Stamford in 1897. During his forty years in Stamford he served on the Board of Education for twenty-three years, in recognition of which the Cloonan Junior High School bears his name.

Doctor Cloonan exemplified the highest standard of ideals. With a true and accurate conception he practised medicine and surgery, his worthiness proved by many outstanding honors during his career as a physician. He courted with favor underprivileged children, in a effort to make their lives in accord with a higher standard as shown by his tireless endeavor of many years as a member of the school board. A man of integrity and honor, he was devout to his church, loved and respected by his patients, and was greatly devoted to his family. Doctor Cloonan was affiliated with many medical, fraternal and business organizations; was Secretary to the Staff, attending surgeon and a member of the Medical Board of the Stamford Hospital, a member of the consulting staff of St. Vincent's Hospital, Bridgeport.

During the administration of the late Governor Simeon Baldwin, Doctor Cloonan was appointed to study and investigate the advisability of convict labor in prisons. During the World War he was medical officer of the Stamford Draft Board.

At the time of his death, Doctor Cloonan was Vice-President of the Fidelity Title and Trust Company, a director of the Mortgage Bond and Title Company, former president and director of the Morris Plan Bank and held membership in the American Medical Association, Connecticut State Medical Society, Fairfield County Medical Association, Stamford Medical Society and a fellowship in the American College of Surgeons. He was also a member of St. Augustine's Council, Knights of Columbus, charter member of the Woodway Golf Club, a trustee of St. John's Catholic Church and a trustee of the Stamford Day Nursery.

In 1899, Doctor Cloonan married Estella McMahon of Baltimore who died in Stamford in 1903; on October 25, 1911, he married Eleanor Patricia Griffin of New York City who died on June 16, 1939. He is survived by two daughters, Gertrude Elizabeth Cloonan and Mrs. Eleanor Barbara Miller of Rye, New York; a son, John J. Cloonan, a senior in Georgetown University

Medical School; a sister, Mrs. Minnie Lyons of Hartford; and two grandchildren, Susan and Donna Miller of Rye, New York.

Ralph W. Crane, M.D.

• Quarto Notes •

THE THROAT DISTEMPER OF 1735-1740

by

Ernest Caulfield M.D.

113 pages $2.50
New Haven, Conn. 1939
Published for the Beaumont Medical Club by
the Yale Journal of Biology and Medicine

Writers of medical history are indeed rare who can produce a volume of such interest and value as this "true history of the terrible epidemic vulgarly called the Throat Distemper which occurred in His Majesty's New England Colonies between the years 1735 and 1740." It should interest physicians of Connecticut the more because written by one of our own number. Every possible source of information bearing on the subject has apparently been scrutinized by the author in establishing the character and extent of this particular epidemic which, as the author has shown, in reality comprised two distinct epidemics of two different diseases.

The volume is very attractive in its blue and gray cover, bearing a fac simile of the bust of Doctor William Beaumont. There is a wealth of cuts and tables within its covers, all adding to the attractiveness and increasing the interest for the reader, Here and there the author lapses into descriptive narrative of old New England scenes, reminders of similar pages in Odell Shepard's "Connecticut, Past and Present."

To Doctor Caulfield we owe a debt of gratitude for this important contribution to medical history.

* * * *

CANCER HANDBOOK OF THE TUMOR CLINIC

Stanford University School of Medicine

by

Eric Liljencrantz, M. D.

114 pages $3.00
Pato Alto, California Stanford Univ. Press 1939

This small book is a revision of the handbook on the diagnosis and treatment of cancer published in 1937. Into the brief space of less than 100 pages is found the basic essentials in the diagnosis and treatment of the more common malignant neoplasms, together with short chapters on the cancer problem and the principles of radiation therapy, and a bibliography. The subject matter is well handled. Such controversial subjects as the management of metastatic cervical glands is very satisfactorily covered in the space of four pages. The book is beautifully printed and bound and contains fifty well chosen diagrams and photographs.

P. G. McLellan

* * * *

THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE ESOPHAGUS

by

Porter P. Vinson
B.S., M.A., M.D., D.Sc., F.A.C.P.
Professor of Bronchoscopy
Medical College of Virginia,
Richmond, Virginia

224 pages $4.00
Springfield, Ill. Charles C. Thomas 1940

This book is dedicated to the late Henry S. Plummer. This name perhaps furnishes a clue to the most interesting chapter in the book, namely those diseases of the esophagus which have come to be listed under the title of Plummer-Vinson Syndrome.

The book as a whole is a very interesting discussion of diseases of the esophagus. It begins with a discussion of general management of patients who have difficulty in swallowing. There is next a short discussion on the methods of esophagoscopy and a discussion of the indications. Then chapter by chapter the various common and less common ailments are discussed, beginning with carcinoma, then going on to cover strictures, cardiospasms, diverticula, and hysterical dysphagia which many of us recognize by the more popular title of Plummer-Vinson Syndrome.

This latter disease the author declares is based on the fear of choking. Most of the patients are not outwardly neurotic. Most of them are women over forty years of age. Because of the prolonged fear of choking, the diet has become limited and as a result there develops a secondary anemia and avitaminosis, the resulting picture marked secondary anemia, enlargement of the spleen, redness of the mucous membrane of the mouth, throat, and esophagus, with marked hyperkeratinization of the epithelium of the tongue, throat and esophagus. The patients generally maintain an adequate caloric intake of food but generally the diet is so deficient in minerals and vitamins, partly due to the fear of swallowing solid foods, and due to glossitis which makes the swallowing more painful. This disease has to be differentiated from pernicious anemia and generally the blood picture is enough to separate it. The treatment consists of a well-balanced diet, extra minerals, esophagoscopy, and relief of fear of choking. It is not a common disease but because of its similarity to pernicious anemia, except for the blood findings, it deserves more consideration than it is generally given.

Next, there is a very good section on foreign bodies and infections and perforations of the esophagus. This book is not an encyclopedia on this score but it does furnish one with considerable information as to what one should know about esophageal foreign bodies and what can be done.

The chapter on the rarer infections of the esophagus is excellent although brief, and for those who wish to go further there is at the end of this chapter, as at the end of all chapters, an excellent bibliography.

This book makes a very good introduction to the field of the esophagus and its disease. It is not complete in every detail but is sufficient to furnish anyone with a good working knowledge of the subject. Its advantages are that much knowledge is packed in its terse discussion of the many subjects included. The book should have an appeal to the internists because of the discussion of diseases and their diagnoses and management; to the surgeon for the discussion of tumors, care of diverticula and other surgical conditions; to the nose and throat man to remind him that there is more to the esophagus than the esophagoscopy.

W. J. Neidlinger.

* * * *

RECTUM AND COLON

by

E. Parker Hayden, M.D.

434 pages 169 engravings $5.50
Philadelphia Lea and Febiger 1939

Using the words "I have attempted in this book to cover the general subject of diseases of the rectum and colon without including unnecessary and unimportant details," Doctor Hayden begins the preface of his book. He could rightfully have written an epilogue and said, "I have done what I attempted in this book."

With this definite purpose, Doctor Hayden has set down in clear, at times vivid words, not only the fundamentals of Coloproctology, but many of the finer details. The book is written in such a style that one has the feeling while reading, as though in actual conversation with the author, answering questions as asked. Descriptions are vivid and concise; treatments are outlined with a conservative precision that is adequate; statistics are cited with an open-minded criticism of their meanings and values.

The arrangement of the text is not new, being divided into chapter discussions of the various conditions. After a brief but perhaps insufficient chapter on Anatomy, there follows one on Methods of Examination and a third on Analysis of Anorectal Symptoms. Then follow the chapters on Pruritus Ani, Anesthesia, Pre and Post Operative Treatment, Fissure, Hemorrhoids, Prolapse, Infections, Fistula, Lymphogranuloma venereum, Genito-Infectious Diseases, Colitis, the Granulomas, Diverticulitis, Benign Tumors, Multiple polyposis, Malignant tumors, Melanosis coli, Megacolon and Volvulus, and Injuries and Foreign bodies.

In addition to the elaboration of the discussions with interesting case histories, good photographs, increasing the ease of understanding, are carefully spaced with relation to subject material.

Bibliographies are short, but sufficient in length and of recent enough material to enable any one so inclined to obtain discussion enough to bring knowledge of the subject to more than an average level.

This book justly deserves a place on every physician's desk, for it is not only a good text and reference book, but is also good reading.

A. Taylor

TUMORS OF THE HANDS AND FEET

by

George T. Pack, B.S., M.D., F.A.C.S.
Assistant Clinical Professor of Surgery,
Yale University School of Medicine

138 pages $3.00
St. Louis C. V. Mosby Co. 1939

Dr. Pack presents a symposium by various authorities which appeared originally in the January 1939 volume of "Surgery." The lesions covered, although of relative infrequent occurrence, are of importance, especially as regards their early diagnosis and treatment. The monograph covers carcinoma, subungual melanoma, angioma, tendon sheath, and bone tumors. Statistical data as well as adequate illustrations of the neoplastic lesions that may occur on the hands and feet, with well accepted methods of treatment give this small monograph a place of value as a reference work and well justifies its reprinting in book form.

P. G. McLellan

* * * *

CITRUS FRUITS AND HEALTH

by

Florida Citrus Commission

73 pages Free
Lakeland, Florida State of Florida 1940

The findings of 75 medical scientists, clinicians, nutritionists, dieticians and contributors to recognized medical journals form the source material of "Citrus Fruits and Health," just issued under the seal of the State of Florida.

The book is one phase of a research program which has been carried on for the last three years by the Florida Citrus Commission, with grants to outstanding scientific institutions for new studies on the health values of oranges, grapefruit and tangerines.

The book is a concise but comprehensive treatment of "the physiology, pathology and therapeutics of the accessory substances as related to the citrus fruits," along with examples, figures and opinions from clinical and scientific sources.

Written especially for the medical and dental professions, the book was prepared with the counsel and cooperation of an advisory board which included internationally recognized authorities in medical and dental research, nutrition and biochemistry.

Although much has been written in the past on the health attributes of citrus fruits, this work is the first to bring into a single volume the various known aspects of the fruits in their relation to health and disease.

"Citrus Fruits and Health" discusses the fruits in their relation to Public Health, Special Diets, Infancy and Growth, Calcium Assimilation, Pregnancy and Lactation, the Teeth, Disease, Increased Metabolic States, Toxemias, Surgical Disease, the Infections, Resistance to Infection, and contains suggested dietary uses of oranges, grapefruit and tangerines.

HEART PATIENTS
THEIR STUDY AND CARE

by

S. Calvin Smith, M.D., Sc. D.

Formerly special heart examiner for the Surgeon General's office during the World War at home and abroad. Author of four small Brochures on heart disease.

116 pages	No illustrations	$2.00
Philadelphia	Lea & Febiger	1939

This little book by Dr. Smith is a simple, practical and straight-forward presentation. It is well arranged and contains only essentials of heart disease with a short discussion of commonly encountered symptoms and signs. Frequent reference is made to examination for hidden infections and "toxemias" which are responsible for many functional and organic disorders of the heart.

On the whole the reviewer agrees with the contents of the book. Aortic stenosis is cited as rare, but it is probably more common than the impression the book conveys. Competitive physical contests in young adult life are stated as the cause of death before 50 in many college athletes. This seems to be an extreme view. Death by acute dilatation of the heart was a common diagnosis a generation ago but is now attributed to probable sudden terminal fibrillation, both auricular and ventricular. Proof of this is not given. Angina pectoris or what possibly might be grouped better as coronary artery disease is referred to as the aristocrat of heart diseases and heart disease of aristocrats. There is a good balance between clinical study and laboratory investigation. "Acute indigestion" is the bete noir of the cardiologists and the most difficult of all obsessions of which to rid the patient once he has evolved this satisfying concept of his trouble.

The profession is urged to recognize heart impairment rather than to wait for gross circulatory failure. Very sanely, he states that heart disease in common with other pathological bodily processes must have a beginning. Dr. Smith for ten years was a general practitioner so that the book should be especially useful for this type of physician. Many good aphorisms to emphasize points are stated. The author has written an excellent and very sane book on heart disease which should be useful as an excellent pocket manual for anyone caring for heart patients. Common problems of every sort associated with heart disease are considered and the suggestions should be most useful. The death of Dr. Smith soon after this book appeared is very regrettable.

J. A, Wentworth

* * * *

PSYCHOPATHIA SEXUALIS

by

Richard von Krafft-Ebing

Professor of Psychiatry and Nervous Diseases, University of Vienna

623 pages		$3.00
New York	Pioneer Publications, Inc.	1939

This revised and enlarged twelfth edition of a well-known work with an introduction and supplement by Doctor Victor Robinson, is an engaging collection of 238 abnormal case histories. Every form of sexual abnormality is exemplified and one gains insight into such conditions as spinal and cerebral neurosis, sado-masochism, fetichism, homosexuality and a variety of other interesting abnormalities in the sexual sphere.

Krafft-Ebing develops an educational and sympathetic theme in this well known study. However, he does not deal with therapy which in such cases must always be on an individual basis. The reader will infer that the patients described require neuropsychiatric attention and in some instances careful segregation. "Sexual bondage should certainly constitute the cause for leniency in crimes committed through its agency," was the central theme of Krafft-Ebing's teaching.

Here and there one finds descriptions in terms non-English which increases the reading time. Also one encounters a certain amount of repetition in the description of types of cases. There are discussions of a medical legal nature and conclusions which should be helpful to those who deal with abnormal sexual problems — e.g. "The question of responsibility in the individual case depends on the psychical conditions by which the offender is actuated — Forensic responsibility in these cases is determined by the question whether the offender succumbed to an irresistable impulse or not — etc."

The book is written in clear, concise style and is essentially a medical treatise. It is recommended to physicians and jurists, and not to laymen.

L. H. Gold

* * * *

SHORT STATURE AND HEIGHT INCREASE

by

C. J. Gerling

159 pages		$3.00
New York	Harvest House	1939

This book, written in clear, readable style, is intended for the adult who is interested in making the most of his inches, or the parent who is concerned about the height of his child. It explains in an engaging and easily understandable manner the commonly held beliefs regarding the factors of growth. It is intimated that much can be done to increase the stature of the boy or girl before the early twenties; thyroid extract is helpful to some; proper diet and special exercises help others; and correct posture is invariably advantageous to all. After the bones are ossified, however, attention must be given to making the most of the stature already attained by always standing erect, following faithfully the exercises precisely set forth and employing certain suggested principles of dress. The author shows by tables kept at Harvard and Vassar that each generation is taller than the one before. He quotes from Dr. Shapiro, anthropologist of the American Museum of Natural History, who believes that this tendency toward increased stature will continue in the future, and he mentions the discouraging lesson of the dinosaurs: "they grew bigger and bigger, finding it more and more difficult to get enough food for daily sustenance, and finally died off, just because they had got too big to live." There is no promise that as the race grows bigger, it will grow better. This book should be helpful to many, and of interest to all who long to be taller.

D. B. Wells

THE SHORT CYCLOPEGIA FOR REFRACTION

(*Continued from Page 140*)

factory. We are also asked whether the drugs can be mixed after the old homatropine-cocaine formula. Satisfactory results have been claimed by some observers. If two solutions are to be combined of course the solutions before mixing should be double strength to avoid dilution.

In short, satisfactory cycloplegia can be obtained by single instillations of cycloplegics with benzedrine. Whether this is a genuine synergy has been questioned. It could be merely that the adrenergics facilitate the instillation. The advantages are first, minimum of instillation, and second, speed of recovery. The method is not infallible but in the same cases seems about as reliable as the conventional practice. Most of the reports we get are enthusiastic. Some of the occasional criticisms seem to indicate an unwarranted faith in the efficiency of the regular methods of cycloplegia.

DOMESTICS' EXAMINATION IS NEGLECTED

"Existing health regulations in most communities still neglect in large measure the safeguards for the health of children in regulating and demanding physical and laboratory examinations of domestics associated with children or engaged in the handling of foodstuffs," *The Journal of the American Medical Association* for Jan. 27 declares.

"Recently there has been renewed interest in the public health aspects of domestic service and in attempts to minimize the health hazards incident to domestic employment by periodic examinations," *The Journal* states. "Additional emphasis is given to this problem by the recent report from the director of public health, San Francisco, of four domestics revealed to be typhoid carriers in 1939. In each instance the carrier was identified after the development of typhoid in the family or, in one instance, in the cafeteria in which the domestic was employed. None of these four carriers ever gave a history of having had the disease. Such circumstances merely serve to reemphasize facts already well known; namely, that only healthy adults should be in contact with children or for that matter with other adults."

U. S. PHARMACOPEIAL CONVENTION

The United States Pharmacopeial Convention for the decennial revision of the United States Pharmacopeia will be held in Washington, D.C., beginning May 14, 1940. Connecticut State Medical Society is entitled to three delegates to this Convention and the Council has appointed as delegates and alternates:

Delegates	*Alternates*
John H. Foster, Waterbury	Howard S. Colwell, New Haven
Louis H. Nahum, New Haven	Carl H. Wies, New London
John A. Wentworth, Hartford	W. Bradford Walker, Cornwall

The School of Medicine of Yale University will be represented by:

Delegates	*Alternates*
Henry G. Barbour	Alfred Gilman
Arthur J. Geiger	Louis S. Goodman
George Blumer	John C. Leonard

NEW YORK SESSION OF THE A.M.A.

"Plans are well under way for one of the greatest annual sessions of the American Medical Association ever held in its history," the Association's *Journal* for Feb. 3 declares in an editorial. "This session is scheduled to take place in New York City, June 10-14 inclusive. The meeting places of the various sections will involve the use of the Waldorf-Astoria, the Commodore, the Roosevelt and the Biltmore hotels; registration of Fellows and all the exhibits will be in the Grand Central Palace. The opening meeting will be held in one of the large assembly halls in the same area."

THE OLD SPANISH PRISONER'S SWINDLE

Physicians in Wisconsin have been solicited to participate in a "get rich quick" scheme. It is the same old story of an individual who is supposed to be confined in a Mexican prison and offers a cash reward to anyone who will assist in getting him out, the method being specified by the solicitor. Such letters should be forwarded to the United States Post Office Department at Washington, D.C., for purposes of prosecution.

MEDICAL BLUE BOOK

The December issue of the Wisconsin Medical Journal took the form of a Medical Blue Book, devoted to laws and rulings affecting the medical profession in Wisconsin. This is to be an annual issue and replaces a former publication financed by the funds of the State Medical Society for which there was considerable demand.

* * *

ADEQUATE MATERNAL CARE IN RURAL AREAS

An adequate program of maternal care in a rural community must be State-wide rather than merely county-wide in scope. The city hospitals, the State medical society, and city obstetric consultants must all play a part if the entire program is to be efficient. In the County, non-medical groups such as women's clubs and parent-teacher associations must be sufficiently interested to disseminate information, afford transportation, and so forth. Certification of indigent patients is a function of the county welfare board. Of greatest importance is the close cooperation of the two most interested agencies, namely, the local physicians and the county health department. The functions of the two, although primarily separate, frequently overlap. Each can do much to help the other, and their combined efforts are necessary for success. It is possible for the physician to make great use of the health department and still maintain his professional integrity and individual personality. It is equally possible for the health department to cooperate with the physician without the adoption of a bureaucratic or heavily paternalistic attitude. The aim on both sides is the same — the lowest possible maternal, stillborn, and neonatal mortality rates. A considerable lowering of maternal and neonatal rates is possible with existing facilities plus the expenditure of a relatively small amount of judiciously placed money. The improvement of community health following better obstetric practice will more than repay the energy and money necessary to accomplish it.

Child, Nov. 1939

CONSULT WI' A SIP!

One sip o' Johnnie Walker wi' soda will convince ye that all's well wi' this grand whisky. Aye, it will tell ye that there's no finer whisky than Scotch... and Johnnie Walker is Scotch at its smooth, mellow best!

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820...
still going strong

Canada Dry Ginger Ale, Inc., New York, N. Y., *Sole Importers*

SILVER PICRATE

Wyeth

Has shown a CONVINCING RECORD* OF EFFECTIVENESS in ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae • Trichomonas vaginalis
Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

DENMARK PROVIDES FOR BUREAUS OF MATERNAL AID

Advice and aid to expectant mothers and mothers recently confined are to be given under a law of 1939 in Denmark which provides for the establishment in various parts of the country of special bureaus of maternal aid.

Women applying to the bureau will be given periodic physical examinations before and after childbirth; also advice and aid in legal and economic matters. Expectant mothers without means of support will be placed in maternity homes and later in an institution for mothers with young children. Efforts will be made to obtain employment for the mother in the institution or elsewhere.

The bureaus may also, within the limits of their resources, improve the situation of the mothers by providing obstetric care, the services of a visiting housekeeper, opportunity to rest after childbirth, advance payments of maternity benefits granted by the State, and through other measures.

Child, Dec. 1939

SIGMUND FREUD

Freud will for two reasons always remain a memorable figure in the history of science. First for the fact that he conquered a new province for science, that of the unconscious mind, with all the associations that go with this of methodological technique and the biologically genetic approach to the mind. Then for the example he has given us of a pioneering investigator, with all the endless patience in observation, freshness of insight and daring readiness to face the unknown, that charaterize the great pioneer. Let me stress above all the last of these qualities. We know that physical courage is — fortunately in these times — a common enough human virtue, that moral courage is rarer, and that rarest of all is intellectual courage. I do not think we know of many figures in the history of the world who have equalled Freud in this rare and transcendent quality.

Proc. Roy. Soc. Med.

Dec. 1939

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1939-1940) 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) 5

ORIGINAL PAPERS:

Future Progress	Arthur B. Landry, M.D., Hartford, Conn.	185
Intestinal Intubation	C. H. Duston, M.D., Waterbury, Conn.	187
Clinical Problems in the New Born Infant	Harry H. Gordon, M.D., New York, N.Y.	191
Focal Infection	John R. Paul, M.D., New Haven, Conn.	198
Prepaid Medical Service	Creighton Barker, M.D., New Haven, Conn.	200
Schonlein-Henoch's Purpura Simulating Acute Surgical Abdomen —	Julian B. Herrman, M.D., New Haven, Conn.	202

ASSOCIATION OF CONNECTICUT TUMOR CLINICS:

Fifteenth Meeting held at Waterbury, December 13, 1939 208

STATE DEPARTMENT OF HEALTH:

Connecticut Mortality in 1939 . . . . . William C. Welling, Hartford, Conn. 212

148TH ANNUAL MEETING — PROGRAM . . . 214

EDITORIALS:

Chemotherapy with the Sulfonamide Derivatives 216
In Restraint of Trade 217
It Can Happen Here 218
The Late Season Cold 219
Radio Cure-Alls . . 220
The Health Officer of Today . 221
The Handbook on Cancer . . 221
The United States Pharmacopeial Convention 222

FROM THE SECRETARY'S OFFICE . 223

CONNECTICUT HOSPITAL ASSOCIATION 224

SECTION ON PROCTOLOGY . 227

THE GENERAL PRACTITONER'S FORUM 227

OUR NEIGHBORS 228

NEWS FROM COUNTY ASSOCIATIONS . 229

LETTERS TO THE EDITOR 232

THE DOCTOR'S OFFICE . . 233

SPECIAL NOTICES . . . 234

OBITUARIES:

George Shattuck Whiteside, M.D.	Wilder Tileston, M.D.	238
Bartholomew Charles Pasuth, M.D.	John G. O'Connell, M.D.	238

QUARTO NOTES (Book Reviews) 239

BEACON OF QUALITY

The Red Lilly dots the shelves of almost all American prescription pharmacies. It is a mark of distinction that is placed upon Lilly pharmaceutical and biological products.

Preparations of Liver for Parenteral Administration

Ampoules Solution Liver Extract Purified, Lilly—contain 15 U.S.P. units per cc. Supplied in 10-cc. ampoules and in packages of three 1-cc. ampoules.

Ampoules Solution Liver Extract Concentrated, Lilly—contain 2 U.S.P. units per cc. Supplied in 10-cc. ampoules and in packages of four 3.5-cc. ampoules.

Ampoules Solution Liver Extract, Lilly—contain 1 U.S.P. unit per cc. Supplied in 10-cc. ampoules.

ELI LILLY AND COMPANY

INDIANAPOLIS, INDIANA, U. S. A.

The Connecticut State Medical Journal

Vol. IV. APRIL, 1940 No. 4

Future Progress*

ARTHUR B. LANDRY, M.D.**
Hartford, Conn.

My part in this program is a discussion of the future progress of The Connecticut State Medical Society and presumably grants me sufficient latitude to express not only my views but also the views of others that deserve consideration. What I shall present here is a composite offering intended to strengthen the Medical Society in its efforts to resolve some of the problems confronting it. It may seem trite to say that we must immediately make an especial effort to gather into the Society every eligible physician practicing in this State and to retain within the fold all present members. In doing so we should bear in mind the reasons why nonmembers have not seen fit to join the Society and why some members contemplate resigning.

There has been a tendency on the part of County Associations to exclude members on the grounds of questioned ethical practice. The word "questioned" is used here advisedly because from personal knowledge I am sure some applicants have been rejected on the circumstantial evidence of unethical practice and it must be remembered that a first rejection may often retard or discourage a second application. Prejudice should not be a factor in the balance weighing an applicant's qualifications.

Secondly, I believe, as many do, that the Society should establish early contact with the beginner in the practice of medicine and explain to him the value of joining his County Association, and all assistance possible should be extended to the young physician desiring to establish himself in practice. The method employed to accomplish these ends may well be left to the County Associations, but its discussion should be an inter-association matter through conferences with the Executive Secretary of the State Society.

While the duties of the county secretaries are defined in the By-laws of the various County Associations there are other matters of such importance as to make it necessary to communicate them immediately to the Executive Secretary of the State Society. For instance, I believe that all threatened malpractice actions should be reported to the State Society office. When changes in the County Association By-laws are proposed they should invariably be submitted to the State Secretary in order to make sure that they do not conflict with the By-laws of the State Society. Difficulties arising in compensation practice or enroachments upon the rights of physicians, no matter where they occur, should also be brought to the attention of the State Secretary and his aid and the aid of the Council sought in their adjustment.

There are County Associations which have not as yet established Boards of Directors or Advisory Boards. They should consider the advisability of doing so for the purpose of keeping the Association active between its two regular meetings. The object of such units within the Associations is to discuss important matters that usually cannot wait until the next regular meeting of the Association. Fairfield

---

*Address presented at the Conference of County Secretaries, February 23, 1940.
**President-Elect, Connecticut State Medical Society.

County and Hartford County now have such bodies that have proved not only their advisability but their necessity. The Councillor who should be a member of such a Board derives from its needs and discussions a thorough understanding of local affairs and knows which ones should come before the Council of the State Society, and in turn, he brings back from the Council valuable information that such local controlling Boards should have.

It will be no surprise to you who are in close contact with County Association members when I tell you that I am amazed at the number of active members who are unaware of the vast amount of work that is done by the State Society and the County Associations to further the interest of medical practice. It is not uncommon to have members ask, "What do I get out of my membership in the State Medical Society?" From this observation it is obvious that we must inform the doctors what we are doing and what we are trying to accomplish.

To extol the advantages and benefits derived from membership in the State Society is important but who is to do this is open to question. It seems to me that we might enumerate and explain these advantages in pamphlet form to be sent to each member and prospective member. Futhermore, it is the duty of the President of each Association to elaborate on this subject at the County meetings and certainly the President of the State Society should, on his visits to the County Associations, make that the theme of his remarks.

The medical profession has an unusual opportunity to inform the people on subjects of mutual interest. The manner in which this should be done is of sufficient moment to demand the attention of the Council of the State Society and the officers of the County Associations. Something has already been accomplished in this field and I mention the activities of the Hartford County Medical Association which, together with the Hartford Medical Society, holds an annual meeting in the city of Hartford to which the public is invited to hear an address on some phase of medical practice given by an outstanding medical authority. Two such meetings have already been held and the Bushnell Memorial has been filled to its capacity of 3,000 persons. In the light of this experience my advice to the County Secretaries is that they convey to their respective Associations the advisability of carrying out a similar program.

There are still some problems existing in hospitals and between hospitals and the medical practice that can be more satisfactorily adjusted through the recently established conference mechanism between the State Society and the Connecticut Hospital Association. The County Associations and especially the County Secretaries have a definite responsibility in this connection in seeing that opportunity is offered for the discussion of these matters.

The work that has already been done by the Clinical Congress Committee has been, in my opinion, of high order. Each year that Committee has made an attempt to improve the quality of the program of the Congress. Excellent as its programs have been, the Committees responsible for them have sought further betterment and the County Secretaries, who should be in close touch with the physicians in their localities, are in a position of prime importance to advise this Committee as to what types of programs would be most acceptable to the physicians throughout the State.

Medicine in industry has not been given the attention from the organized profession that it deserves. From my own observation, together with information obtained from other physicians, it is evident that the health of industrial workers, as well as the health of employees in other fields of endeavor has been affected by the weight and pressure and accelerated tempo of business. The strain incident to operative methods employed by labor frequently reflects itself in nervous disorders and physiological disfunctions and ultimately, I believe, in organic disease. I feel that the Committee on Industrial Health should immediately plan a method of study of employees for the purpose of determining to what extent employment affects the health of employees. The part that the County Association and County Secretaries can fill in this activity is most important for there are local variables in industry that are best understood by local physicians.

The State Committee on Workmen's Compensation, made up of five Committees, one in each of the congressional districts, has been practically inactive for several years. While

(Concluded on Page 226)

Intestinal Intubation*

C. H. DUSTON, M.D.,**
Waterbury, Conn.

The local treatment of intestinal obstruction has consisted of reducing distension, locating and relieving the obstruction and removing gangrenous gut if it is present. I plan to review here a procedure which has been proposed to facilitate this treatment.

The role played by distension in intestinal obstruction and the increased operative risk when it is present, is well known. A typical critical picture of intestinal obstruction has been reproduced experimentally by Herrin and Meek by mere distension without mechanical obstruction. *Wageensteen* in 1933 demonstrated the therapeutic value of gastric and duodenal suction in relieving distension; and the universal use of his technique at the present time confirms his observations. He has stated that the only short-comings of this suction drainage as he recommended were, that first, drainage of gut done at a point remote from the site of obstruction, necessitates the removal of a much greater quantity of gas and fluid than by an adjacent enterostomy, and second, that the gut above the obstruction cannot be used as a nutritive tube.

Doctor William Abbott and his associates have developed an apparatus which has aided in a dissolution of these short-comings. This consists of a double lumened tube ten to 12 feet in length (18 fr.) near the distal end of which is attached a balloon into which one lumen opens, so that it may be inflated or deflated from the proximal end. After passing the tube into the duodenum the balloon is inflated and the intestine proximal to it, having been restored to normal tone by constant suction, propels it forward dragging the tube behind it. This technique has made it possible to pass a tube completely through the intestinal tract, so that the beneficial results of surgical enterostomy may be reproduced without the operative risk.

The Miller-Abbott tube, as it is known, is passed through the nose, with or without cocainization depending upon the sensitivity of the patient, so that about 9 or 10 inches enter the stomach. The patient is then turned on to the right side and allowed to rest for about 20 minutes until the stomach becomes accustomed to the tube and then it is fed slowly ½ to 1 inch every 5 minutes. Lying on the right side apparently facilitates passage through the duodenum although this may be accomplished regardless of the position of the patient. Indication of passage into the duodenum is easily obtained by portable roentgenogram, although Abbott spoke of using the fluoroscope. The former does not require moving of the patient. Occasionally change in the color of the aspirated fluid may give a clue to passage into the duodenum. Once beyond the sphincter the balloon is inflated with about 50 cc. of air or water and the tube fed slowly through the nose about 2 feet per hour. Usually a rhythmic sense of resistance may be felt in a freely movable syringe plunger after the balloon is inflated in the duodenum, in contrast to an absence of resistance, if it is inflated in the stomach. About 6 to 8 feet of tubing is adequate to extend from the pylorus to the cecum. To remove the tube the balloon is deflated and the tube may be drawn out through the nose in about 5 minutes.

I have attempted intestinal intubation in eight cases and in every instance it was possible to pass the tube to the desired level. In seven of these cases passage through the pyloric sphincter was accomplished in an average time of 4½ hours. In the eighth case, which was fortunately not an operative emergency, 48 hours passed before successful passage into the the small intestine. Because of the time involved this case should probably be classified as a failure. Nitrates were employed in this case in an attempt to relax the sphincter, but

---

*Presented at the Monthly Staff Meeting of St. Mary's Hospital, December, 1939
**Surgical Resident — St. Mary's Hospital, Waterbury

they were apparently of no value. In another the patient's condition was such that she could be moved to the fluoroscopy room where it was possible to manually guide the tube through the sphincter.

The fact that intestinal intubation may be time consuming to a patient who is already a poor operative risk is an objection worthy of consideration. However, the average time consumed is no longer than may safely be employed in using gastric suction as a pre-operative measure. Suction is constant during the procedure and if, after a reasonable interval, intubation is not obtained the patient has not been jeopardized. If successful, however, the patient may be converted to a better operative risk, further diagnostic measures may be taken and in some events the need of surgical intervention is obviated. As Abbott phrases it an emergency is converted into elective surgery.

Intestinal intubation will undoubtedly prove of great value to the roentgenologist. About 50 cc. of a contrast media may be placed directly at the site of obstruction in the decompressed bowel and the nature of the lesion more accurately determined. Moreover, this material may easily be withdrawn eliminating the risk ordinarliy associated with such a procedure. An inflated balloon may be used in some cases to control the passage of a barium meal through the intestine. The tube may be modified so that an opaque media may be held between two balloons placed any desired distance apart, allowing a more controlled segmental study of the intestine. By this means Lofstrom and Noer of Detroit are now undertaking a study of intestine pattern, correlating an analysis of intestinal secretions with the roentgen picture in each segment.

Of course intestinal intubation cannot be taken as a panacea and its success must depend upon the intelligent selection of suitable cases. The indiscriminate use of this method can only lead to its discredit. It should be used by the surgeon reasonably certain of the underlying pathology. The danger of this technique in cases of strangulation is evident. However, in the City of Detroit receiving hospital where intestinal intubation is employed by Johnston, Noer, Penberthy and Denning, of twelve cases of strangulation admitted, all were operated without delay. Errors in diagnosis are more frequent in calling non-strangulated lesions strangulated. External strangulation is easily recognized and internal strangulation, usually caused by internal hernia, volvulus and intussusception, has a relativley low incidence.

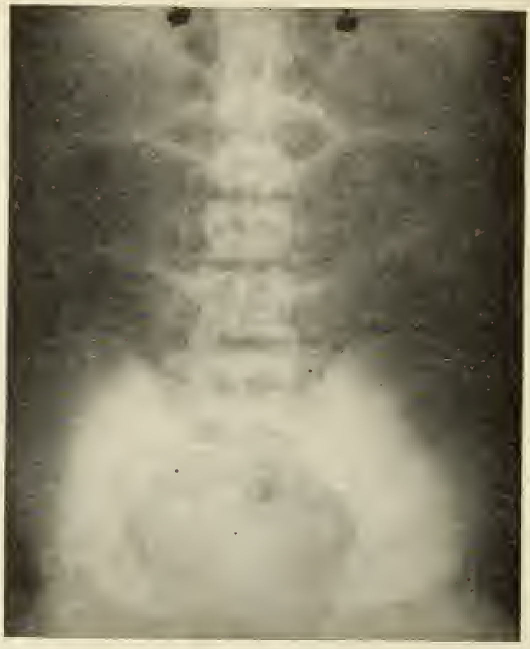


Fig. 1. X-ray showing intestinal obstruction.

REVIEW OF CASES—ST. MARY'S HOSPITAL

Case I. A 34 year old white female complained of weight loss and abdominal pain of 4 months duration with distension and vomiting one week. Miller-Abbott tube was passed on the following day and 24 hours later exploratory laparotomy was performed. Metastic carcinoma involving peritoneum, uterus, ovaries, bladder and descending colon was found. Inoperable mass was found obstructing the sigmoid. The bowel proximal to the obstructing tumor mass was completely collapsed and of normal tone. The Miller-Abbott tube extended to within one foot of the ileo-cecal valve. Cecostomy was performed and patient made a good post-operative recovery. Intubation in this case served as a pre-operative measure.

Case II. A 28 year old colored female complained of distension, abdominal cramps and no bowel movements or flatus for ten days duration. Past history obtained of two previous operations for lysis of post-operative adhesions. Miller-Abbott tube inserted on admission and mid-ileum easily reached. Despite suction for one week, abdominal cramps were not completely relieved and laparotomy revealed very extensive adhesions with multiple partial obstruction of ileum. Ileostomy was performed and Miller-Abbott drainage continued intermittently for ten days. Patient improved steadily but sudden death occurred three weeks post-operative from massive pulmonary embolus.

Case III. A 62 year old white female complained of vomiting, abdominal cramps and distension for one week. Condition was very poor and patient definitely a poor operative risk. Miller-Abbott tube passed easily with beginning relief of distension but patient died 32 hours after admission. Autopsy one hour post-mortem showed marked distension of the large intestines with no distension of the jejunum and very slight distension of the distal portion of the ileum. This case shows the closed piston action of the ileo-cecal valve in obstructions of the colon, as demonstrated by *Wangeensteen*, as the site of the obstruction was in the sigmoid. It shows the limitation of the Miller-Abbott tube in cases of large bowel obstruction although in this case operative inteference was out of the question.

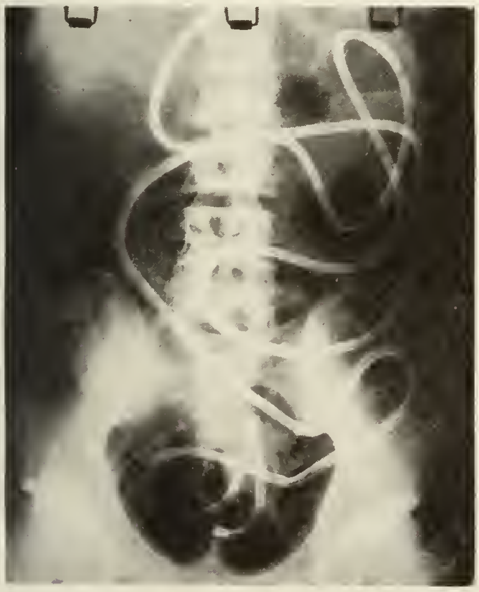


Fig. 2. Miller-Abbott tube in place.

Case IV. A 63 year old white male complained of gastric colic, chills, fever and anuria of two days duration. There was a heavy trace of albumin and a large number of pus cells in the urine. ? Pyelonephritis. Three days later patient became markedly distended Gastric suction was employed with prostigmin, saline, and heat to the abdomen without relief. Peristalsis was absent even at the height of colic. Adynamic ileus was evident Miller-Abbott tube was passed to the ileum and in two days peristalsis had been restored, the abdomen was soft and the bowels were moving.

Case V. A 62 year old female was admitted for chronic cholecystitis with common duct stone and jaundice. Choledochostomy with removal of common duct stone and catheterization of common and hepatic ducts was performed. Gastric suction was employed post-operative, but in spite of this patient developed typical adynamic ileus and marked distension three days after operation. Intestinal intubation was performed with the Miller-Abbott tube and in two days peristalsis had been restored and distension completely relieved. She was discharged recovered 12 days post operative. In this and case three, the passage of the duodenal sphincter was so evident that x-ray records were not taken.

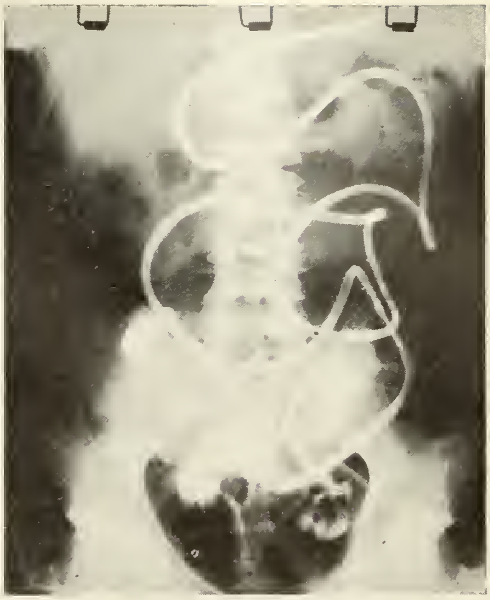


Fig. 3. Barium injected through tube at site of obstruction.

Case VI. A 44 year old white female was admitted for hysterectomy because of myometrial endometriosis and endometrial polyp. She developed adhesive intestinal obstruction and partial evisceration and was operated upon again five days following first operation for lysis of adhesions. Ten days later patient had recurrence of intestinal obstruction and intubation was attempted. It was forty eight hours before a tube could be passed through the pylorus. Intestinal drainage was kept up seventeen days and when symptoms of obstruction became increased surgical intervention was deemed necessary. Extensive adhesions were found throughout the small bowel matting them together and to the abdomial wall. Ileostomy and lysis of adhesions were performed. Patient discharged twenty days later, symptom free. This case illustrated the time that can safely be employed keeping such cases under observation pending relief or necessity of surgical intervention.

Case VII. A 40 year old white male was operated upon for an acute perforated gangrenous appendicitis. Nine days post-operative patient developed a complete adhesive obstruction. Adhesions were freed surgically and *Wangeensteen* drainage used post-operatively. Ten days later patient had recurrence of vomiting, distension and abdominal colic. X-ray revealed recurrence of intestinal obstruction. Miller-Abbott tube was passed easily and pain and distension relieved in twenty four hours. Tube was left in place for three days and suction topped without recurrence of symptoms. Tube was then removed and patient discharged two weeks later symptom free.

Case VIII. An eight year old male was admitted for R. L. Q. pain and vomiting of three days duration. Acute catarrhal appendix with suggestive beginning suppuration was removed. Three days post-operative patient developed very marked distension not relieved by gastric suction, heat to abdomen, rectal tube, prostigmin and 500 cc. ten per cent saline i.v. and oxygen tent. There was no audible peristalsis even at height of colic. Patient eviscerated a small loop of intestine. The wound edges were approximated with sterile tape and the Miller-Abbott tube easily passed. The distension was completely relieved in forty eight hours. Tube was left in place four days. Ten days later this patient developed chorea and was kept in bed two months until all manifestations of activity had ceased. Discharged recovered. It is quite certain that intestional intubation in this case meant the difference between life and death.

I summarized the instances of intestinal intubation at this hospital in the hope that it may stimulate its more wide spread employment in suitable cases and possibly uncover further uses for what apparently shall be a valuable addition to the physician's armamentarium against disease.

Summary

In summary it may be stated that intestinal intubation by means of the Miller-Abbott tube offers a method that, provides

1. excellent pre-operative treatment by relieving distension and edema of the gut, by permitting oral as well as parenteral nutrition and thus simplifying any required surgical procedure;
2. diagnostic aid by affording x-ray a means of identifying the site and occasionally the nature of the lesion and keeping the patient in good condition while diagnostic procedures are being employed;
3. a means of occasionally obviating operation, especially in the cases of certain types of recurrent adhesive obstruction and of adynamic ileus where it seemingly will have its most dramatic results;
4. prophylaxis against post-operative distension in cases where it is likely to be a serious complication.

BIBLIOGRAPHY

1. Herrin, R. C. & Meek, W. J. — Distension as a Factor in Intestinal Obstruction. Arch. Int. Med. 51:152-Jan. 1933.

2. Wangeensteen, O.H. — Distension as a Factor in Intestinal Obstruction. Arch. Int. Med. — 51:152, Jan. 1933.

3. Wangeensteen, O. H. — The Therapeutic Problem in Bowel Obstruction — C. Thomas Co.

4. Johnston, Penberthy, Noer, Kenring — Decompression of the Small Intestine in the Treatment of Intestinal Obstruction — J.A.M.A. 111:15 — Oct. 1939.

5. Wangeensteen, O. H. — Therapeutic Consideration of the Management of Acute Intestinal Obstruction — Arch. of Surg. 26:6 June, 1933.

6. Lofstrom & Noer — Use of Intestinal Intubation in the Localization of Lesions of the Gastro Intestinal Tract — Am. J. of Roentgenology and Radium Therapy-42 321-331, 1929.

7. Abbott, W. O. and Johnston, C. G. — Intubation Studies of the Small Intestines. Non-surgical method of treating, localizing and diagnosing the nature of obstructive lesions — Surg. Gynec & Obs. 66-691-697. 1938.

8. Abbott, W. O. — The Treatment of Intestinal Obstruction and a procedure for identifying the lesion — Arch. Int. Medicine 63:3 — March, 1939.

9. Miller, T. G. & Abbott, W.O. — Intestinal Intubation Practical Technique — Am. J. M. Sc. 1934-187, 595-599.

⁂

THE INDUSTRIAL PHYSICIAN

There is much to do with, for and through the industrial physician. There is the clarification of relationships between him on the one hand and on the other hand the employer, the employee, the industrial nurse, the insurance company, the compensation commission, the fellow industrial physician and, last but not least, the private practitioner.

This in turn involves considerations that we can only hint at now — the pre-employment and periodic health examination, the plant inspection, the control of leading causes of occupational morbidity and mortality, as, for example, tuberculosis, more thought to the personal and mental hygiene of the worker, the problems of the elderly worker, the industrial significance of non-industrial disease, the relation of trauma to disease.

We believe the industrial physician will ultimately desire adequate recognition of his status as, for example, certification by an American Board of Industrial Medicine. This we have already brought to the attention of the Council's Secretary who has judiciously remarked that such certification in turn will be dependent on the very formulation of standards, which we are only now arriving at through the identification of the industrial physician and by a study of his methods and ideals.

(From paper on Organized Medicine and Industrial Health by Clifford Kuh, M.D., delivered at 2nd Annual Congress on Industrial Health, Chicago, Jan. 15, 1940.)

Clinical Problems in the Newborn Infant*†

HARRY H. GORDON, M.D.,
New York, N. Y.

During the past few decades the decrease in neonatal deaths has been insignificant in comparison with the decrease in total infant mortality. In 1935, for example, the Children's Bureau reports almost 80,000 deaths in infants under one month, half of these occurring on the first day of life. Accordingly, a discussion of clinical problems in the newborn infant seems timely. Since whole books have been devoted to comprehensive reviews of the subject, the aim of the present paper is limited to a consideration of some of the physiologic adjustments in the newborn infant which may contribute to the development of symptoms, followed by a brief discussion of a few specific problems, such as prematurity, asphyxia, bleeding, diarrhea and feeding.

Relation of Physiological Adjustments to Symptoms

Until the time of birth the infant has been floating around in warm amniotic fluid, the maternal organism supplying him with food and ridding him of waste products. At birth he is subjected to physical forces which have been compared to those of an automobile crack-up and he is required, in the bargain, to utilize in full those complex regulatory mechanisms which will insure for him a constant internal milieu in the presence of changing external conditions. If these physiologic adjustments to the striking change in his conditions of life are not made smoothly, manifold symptoms may arise.

A most important group of symptoms are referable to the change in mode of respiration. Successful adjustment to the new conditions of respiration requires a patent respiratory tract, proper neuro-humoral control of respiratory rate and rhythm, and adequate circulation through the pulmonary capillaries. Accordingly, a symptom such as cyanosis or atelectasis may arise from obstruction of the respiratory tract by aspiration of mucus, contents of the birth canal, or milk. Apneic attacks and asphyxia may result from depression of the respiratory center by excessive narcosis, by cerebral hemorrhage, or by prolonged anoxemia. Finally, defective circulation, due to congenital cardiac malformation, may give rise to cyanosis.

Another group of symptoms is related to the change in mode of obtaining nourishment. For this the newborn infant must have adequate sucking and swallowing reflexes, a patent digestive tract, proper gastro-intestinal motility and secretion of enzymes. As an added burden, by contrast with the respiratory adjustment in which most infants will in the natural course of events inhale a satisfactory gas mixture containing 20 per cent oxygen, the food supply is subject to potentially unwise manipulation.

Symptoms referable to failure of this adjustment are refusal to nurse and vomiting, which, if prolonged, may lead to dehydration, with its resultant fever and renal failure, or to marasmus. These difficulties in feeding may be important manifestations of cerebral defect or cerebral injury or be due to the swallowing of mucus which yields quickly to gastric lavage. Vomiting may be caused by duodenal bands, by congenital pyloric tumor, by pylorospasm, or by the ingestion of a feeding mixture in excessive amounts or of improper composition Vomiting may occur as a result of over distention of the stomach with swallowed air. The latter varies inversely with the amount of nursing service since it is common practice for harassed nurses to prop-bottles on pillows, paying little attention to the necessity for keeping the neck of the bottle filled with fluid.

Another group of symptoms is referable to changes in the blood. There is normally a striking drop in erythrocytes during the first weeks of life and a large amount of hemoglobin will claim excretion as bile pigment. The ratio of the rate of this hemolysis to the level of hepatic function will determine the occurrence, duration, and degree of jaundice. Its occurrence at birth in association with yellow amniotic fluid indicates that hemolysis far in excess of hepatic excretory powers has already taken place and carries a grave prognosis. This icterus gravis may be associated with severe anemia and erythroblastosis and be a familial disease or a part of septicemia or congenital lues. If the degree of icterus in the infant becomes disturbing to the physician during the first few days of life, examination of the blood is indicated because a severe anemia may be developing, the pallor of which is masked by the jaundice.

---

*From the New York Hospital, the Department of Pediatrics, Cornell University Medical College, and the Children's Bureau, U. S. Department of Labor.

†Read before the 15th Clinical Congress, Connecticut State Medical Society, September 19-21, 1939.

The finding of moderate numbers of erythroblasts in the circulating blood does not necessarily carry a fatal prognosis. The outpouring of these cells represents in some infants the response of young erythropoietic tissue to anemia in the newborn infant, and we have learned to hesitate to make the descriptive diagnosis, erythroblastic anemia, because of its usual connotation of malignancy.

Occasionally a hypochromatic anemia will manifest itself in the first few days of life, with no symptoms be sides pallor. This condition has been glibly diagnosed nutritional anemia because of the resemblance of the blood to that found in the nutritional anemia of later infancy, and, in fact, in some cases the condition seems to spring from iron deficiency in the mother. In other cases, however, the limited or poor response to the administration of iron, suggests that some defect existed in the infants' ability to use this mineral. Transfusions have been of benefit in these cases restoring the hemoglobin level to normal, sometimes permanently, sometimes temporarily.

Knowledge of the etiology of blood dyscrasia in newborn infants is so meagre that further discussion in this limited presentation would be fruitless. In some instances familial constitutional factors are of importance; in some, maternal nutritional factors; in some, inadequacy of the infant's erythropoietic function. In still others the rapid development of severe hemolysis, jaundice, listlessness and prostration suggests an overwhelming toxemia or infection. At any rate, frequent hematologic examinations and the ready use of transfusions of citrated matched blood are generally indicated.

The next symptoms are referable to changes in the mode of excretion. At birth proper kidney function in the infant becomes of vital importance in the regulation of water and acid-base balance and in the excretion of nitrogenous waste products, and interference with urine flow by congenital anomaly or dehydration may have dire consequences. We have recently had under observation in the New York Hospital an infant of one year, formerly resident in New Haven, who was admitted to the New Haven Hospital at the age of one month with convulsions and a blood N. P. N. of 100, the symptoms stemming from renal failure, due to a congenital ureteral anomaly. Such urinary stasis offers, in this age period, fertile soil for infection manifested by pyuria.

Congenital obliteration of the bile ducts, interfering with excretion of bile, may manifest itself shortly after birth in jaundice with clay colored stools, and poor fat absorption may lead to marasmus unless adequate food is given in an absorbable form. Congenital intestinal atresias may cause constipation with varying amounts of vomiting, depending on the level and degree of the obstruction. Obstipation heralding an ultimate megacolon may occur at this age and distention may be sufficiently severe to result in respiratory difficulty.

Symptoms may develop referable to changes in endocrine function. Placental transfer of maternal hormones may produce some engorgement of the breasts and vaginal discharge or bleeding in the newborn infant. Mastitis and vaginal hemorrhage represent pathological exaggerations of these symptoms. The adrenal gland of the newborn infant, which has attained a relatively large size under the influence of maternal pituitary hormones, undergoes a marked shrinkage immediately after birth; during this period the reticular zone is markedly congested, providing the locus for adrenal hemorrhage, with resultant circulatory collapse. Convulsions associated with low blood calcium and high blood phosphorus are occasionally seen in the neonate and it has been suggested that they represent manifestations of a transient hypoparathyroidism. Because the convulsions readily yield to calcium therapy and therefore a good prognosis may be given, the blood calcium should be determined whenever possible in newborn infants with convulsions. Convulsions may occur in infants born to diabetic mothers.

These are presumably due to hypoglycemia resulting from hyperinsulinism caused by hypertrophy of the infant's islands of Langerhans.

Symptoms may develop which are due to the change from an environment of thermal equilibrium to one of lower temperature which requires regulation of both heat loss and heat production if body temperature is to be maintained. Accordingly, inadequate control of environmental temperature and inadequate nursing will result in subnormal body temperatures unless special measures are taken to prevent heat loss. Injudicious use of these measures and dehydration which interferes with evaporation of water from the skin may both cause fever. These symptoms will occur particularly when inadequate nursing service is supplied for a busy nursery, on the all-too-common assumption that newborn babies require little attention.

As a final physiologic adjustment of tremendous importance, we must note the large increase at birth in the number of portals of entry for infection. Between the umbilical blood of the fetus and the pathogenic organisms of the external world lies all of the mother's humoral and tissue immunity. At birth, in addition to the umbilicus, the infant's skin, respiratory and digestive tracts become possible portals of entry, and it is important that he receive gentle care of the skin and mucous membranes, that there be proper sterilization of his food and feeding utensils, that there be effective restriction of visitors and close supervision of attending personnel in order to prevent the numerous exposures which may lead to bacteremia, impetigo, pneumonia, and diarrhea.

Prematurity

Special discussion has been assigned to this subject because premature birth is responsible for 50 per cent of neonatal deaths. What are some of the handicaps of premature birth and what measures can be taken to mitigate them?

The premature infant has a disability in regulation of body temperature. His handicap stems from the following: he has a relatively large surface area for the loss of heat by radiation in proportion to the mass of heat-producing tissues (most animals of this size have fur coats as compensation); he has very little insulating fatty tissue; he has feeble muscular development with low total heat production; his sweating mechanism is incompletely developed, so that he does not as readily adjust to the application of excessive external heat.

HANDICAPS OF PREMATURE BIRTH

Body Temperature:	Large surface for radiation; poor fatty insulation; feeble muscular development; undeveloped sweating mechanism.
Respiration:	Weak muscles, soft thorax; poor gag and cough reflexes; incomplete development of capillaries; incomplete development of neuro-humoral control.
Feeding:	Weak sucking and swallowing reflexes; low secretion of HCl; faulty absorption of fat; incomplete storage of iron and calcium.
Low Resistance to Infection.	
Increased Capillary Fragility.	

FIGURE 1.

The circulatory and respiratory system are called on to function in the presence of weak muscles of respiration, a soft, bony thoracic cage, weak gag and cough reflexes which permit ready aspiration of foreign material, an incomplete development of capillaries throughout the body, which possibly interferes with gaseous exchange both in the lungs and in the tissues, and an incomplete development of neurohumoral control of respiratory rate and rhythm, manifesting itself in spontaneous attacks of apnea which are relatively unresponsive to given concentrations of carbon dioxide.

The digestive tract is called upon to ingest, digest and absorb food of adequate caloric value, vitamins, fluid, and minerals in the presence of weak sucking and swallowing reflexes, a low secretion of hydrochloric acid, a faulty mechanism for absorption of fat, and incomplete storage of iron and calcium prior to birth.

In addition, the premature infant has marked susceptibility to infections. This may be due to the abbreviation by premature birth of the period for placental transfer of protective antibodies from the mother, or it may be related to the low protein content of the blood serum. Finally, the capillaries of the premature infant are particularly fragile and therefore easily traumatized.

What can be done to mitigate the intensity of these handicaps? The inverse relationship between birth weight and mortality indicates the desirability of delaying premature birth as long as is compatible with obstetric judgment. The handling of a newborn premature baby should be considered an emergency and there should be prepared for the reception of all premature infants (a) a warm bed, (b) suitable apparatus for resuscitation, including a simple suction device and a tank of oxygen, (c) at least one person whose sole responsibility at the delivery will be the care of the premature baby. Unit space should be supplied for his subsequent care, separate from the space for other newborn and for sick infants. This should provide (a) automatic control of temperature at about 80° and of relative humidity at about 60 per cent, (b) special precautions to protect against infection, such as restriction of visitors, individual equipment and a wash bowl for scrubbing hands.

There should be adequate amounts of skilled nursing service. This has recently been defined in the New York City Sanitary Code as one nurse for every three babies throughout the 24 hours. Not every nurse with pediatric training in necessarily qualified to take care of premature infants. At the New York Hospital only those graduate nurses who have proven specially proficient in the handling of sick infants and only those student nurses with outstanding qualifications are permitted to work in the nurseries for premature infants.

There should be continuous medical, preferably pediatric, supervision of these infants. Because of their weak sucking reflex and well-known predisposition to gastro-intestinal disorders, it is important to feed the minimum amount of fluid and food that will permit satisfactory growth. Recent work indicates that approximately 120 calories and 150 cc. of fluid per kilogram, that is, 55 calories and 2 to 2½ ounces per pound, will cover the requirements of most infants after the second week of life. During the first two weeks of life smaller amounts will probably suffice. Because of the partial inability of many premature infants to absorb fat, feeding mixtures, such as the one-half skim milk formulas used here at the New Haven Hospital, seem desirable.

Human milk remains the food of choice for premature infants in view of the long standing clinical impression of its superiority and in the absence of carefully controlled clinical studies comparing it with the best artificial feeding. Many premature infants have done well, however, on proper feeding mixtures of cow's milk. The current quotation for human milk (25 to 35 cents an ounce) makes one hesitate before ordering it for parents with a limited budget.

It is of prime importance that the premature infant be given small, frequent feedings to prevent exhaustion, regurgitation and vomiting. A 2 or 3-hour interval for feeding may be used and for small or young infants gavage or a medicine dropper may be required. Small hypodermoclyses of normal saline solution may be required if the infant is unable to ingest enough fluid to prevent dehydration as indicated by depression of the fontanelle and loss of skin elasticity.

Concentrates of the fat soluble vitamins A and D should be used instead of cod-liver oil because of the sucking disability of these infants, because of their weak gag reflexes which permit ready aspiration, and because of their partial defect in fat absorption.

Transfusions are frequently of great aid to premature infants with bleeding, anemia, infections and diarrhea. It is the custom at the New York Hospital to transfuse all premature infants weighing under 1,500 grams, or 3 pounds, twice during the first 48 hours of life.

Pamphlets issued by different state departments of health and by the Children's Bureau offer many suggestions concerning the proper care of premature infants with much simpler equipment than is available in large hospitals.

Asphyxia

Asphyxia is a major feature of three common causes of death of newborn infants, namely, cerebral hemorrhage, prematurity and atelectasis. The clinical picture of cyanosis, irregular respirations and atony will not be reviewed here. It is of practical importance, however, to stress two factors in respiratory difficulty, the fundamental cause of death in asphyxia. Respiration in both premature and mature infants is hampered by obstruction of the respiratory tract and by depression of the respiratory center by narcotics, cerebral hemorrhage, or prolonged anoxemia. Anoxemia may be due to premature separation of the placenta, to prolapse of the cord, or to any of the causes of asphyxia.

What therapeutic lessons can be learned from these facts? We must be prepared to treat for asphyxia infants born to mothers who have received large doses of anesthetics and drugs, infants born after a hard labor, premature infants, infants born after prolapse of the cord and those who have aspirated mucos or birth canal contents. This treatment should consist, first, of attempts to clear the respiratory tract by gentle suction applied to the mouth and rhinopharynx, and, in occasional instances, where obstruction persists in the larynx or trachea, expert use of apparatus for suction of the trachea may prove of value. The second step is to combat vigorously anoxemia, for a vicious cycle may be set up in which asphyxia leads to anoxemia which in turn leads to further depression of the respiratory center and finally to death. For this, oxygen inhalation is obviously the method of choice. Yandell Henderson has advocated the use of 5 per cent to 10 per cent carbon dioxide in oxygen, but Eastman has pointed out that asphyxiated infants already have increased carbon dioxide in the blood. To my knowledge, carefully controlled clinical studies of asphyxiated infants, comparing oxygen with oxygen-carbon dioxide mixtures, have not been made. In anoxemic dogs, however, Eastman has found definite advantages in the use of oxygen over oxygen-carbon dioxide mixtures.

Mention should be made of the fact that it is frequently necessary to combine oxygen inhalation with gentle artificial respiration, that mechanical devices for long continued artificial respiration have in general not proven satisfactory, that mouth-to-mouth insufflation through a sterile piece of gauze has proven of some value in starting respirations, and that violent acrobatics carry more danger than benefit for the asphyxiated newborn infant. If respiration is established but cyanosis persists, the use of a simple open box oxygen tent, such as that described by Burgess, has proven an adequate and cheap method for long continued oxygen administration.

Hemorrhagic Diathesis

Discussion has recently arisen of the possibility that a bleeding tendency in the newborn infant associated with a deficiency of vitamin K might contribute to the large number of deaths due to cerebral hemorrhage. It is difficult to determine from the literature how frequently a bleeding tendency is associated with cerebral hemorrhage in these infants. In two recent small series of infants with cerebral hemorrhage, one of post mortem, the other of clinical material, it is stated that a hemorrhagic diathesis occurred in 3 per cent and 15 per cent of infants, respectively, but it is probable that even these figures may be too high to apply in all localities.

Remembering, then, that birth trauma is the most important factor in producing cerebral hemorrhage, we have listed other factors which may exaggerate the hemorrhage. First, there is prematurity. The premature infant has particularly fragile capillaries which are easily torn or may even permit extensive oozing of blood without gross tears. Second, the anoxemia of asphyxia renders capillaries more permeable to the blood dammed up by associated venous engorgement. Third, infections such as congenital lues or sepsis may be associated with hemorrhagic tendency. Fourth, toxemia in the mother is considered to predispose to hemorrhage in the infant, although this may be due to the frequent association of toxemia with prematurity. Fifth, subclinical scurvy has been suggested as a contributory factor, and since it has been shown that the infant's blood ascorbic acid content reflects that of the maternal blood, this may be of importance in the offspring of mothers who have had diets deficient in vitamin C. Finally, an insufficiency of vitamin K, with a resultant diminution of prothrombin in the blood has recently been proposed as a cause for bleeding in the newborn infant. The "prothrombin clotting time" has been found to lengthen markedly after the first forty-eight hours of life and this has been suggested as a possible cause for hemorrhagic disease in the newborn infant. Futhermore, the administration of vitamin K has been found to cause marked shortening of the prothrombin time in several newborn infants with prolonged "prothrombin clotting time."

The significance of these findings is not yet clear because the complexity of the clotting mechanism makes present methods of bio-assay of prothrombin difficult of interpretation and the number of infants studied is small. Transfusion of blood remains the most reliable method of remedying a defect in the clotting mechanism and, except for experimental purposes, one is not yet justified in substituting vitamin K therapy for transfusion.

Diarrhea

Diarrhea has been listed for discussion because of the recent epidemics in newborn infants and the high case fatality rate. Several points have emerged from our fortunately limited experience at the New York Hospital. The clinical features in two outbreaks on our pavilion nurseries have varied strikingly. In the first outbreak the infants showed no constitutional symptoms and the frequency of stools decreased with simple changes in feeding. In the second epidemic, which affected fourteen infants, all became acutely and gravely sick, some appearing moribund within twenty-four hours after the onset. The prompt institution of radical therapy was associated with complete recovery of all fourteen infants. This treatment consisted of starvation, the vigorous administration of parenteral fluids, transfusions of blood and slow resumption of feeding. On first glance such treatment may seem drastic for newborn infants, but the effects of dehydration should be fought even more vigorously in infants whose powers of adaptation are already taxed.

Prompt steps must be taken to limit the spread of this highly infectious disease. By stopping all new admissions to pavilions where diarrhea had occurred, by transferring all infants with diarrhea to a separate pavilion, by completely repainting all of the contaminated pavilions, including nurseries, mothers' rooms and utility rooms, the morbidity rates in these two outbreaks were limited to 18 per cent and 6 per cent respectively.

These epidemics of diarrhea serve to focus the whole question of the prevention of infections in newborn infants. There can be no doubt that present nursery practice, particularly in large hospitals, has greatly increased the number of sources of infection with which a newborn infant comes into contact. If we are to prevent infections, we must think, then, in terms of stricter supervision of nursery technique and traffic or of breaking down nurseries into smaller units.

Feeding

Because the mother does not have a food supply ready for the infant at birth, many types of prelacteal feedings have been suggested. The usual criteria of their efficacy are mitigation of the initial weight loss, speed of return to birth weight, and ultimate adequacy of the mother's breast milk supply. The latter is unquestionably the most important single criterion since prelacteal feeding by definition should aim to tide the infant over the first few days until the mother's milk supply is established. The exact composition of the initial weight loss has not yet been determined, but the major portion of it is probably water and there is an associated depletion of glycogen reserves indicated by a sharp drop in respiratory quotient. Accordingly, a simple solution of sugar in water seems indicated as a prelacteal feeding and, in fact, 5 per cent lactose solution has proven satisfactory. A recent report has shown that more infants were discharged from the hospital on breast milk when lactose solution was used as a prelacteal feeding than when water alone or a cow's milk mixture was used. A comparative survey was recently reported indicating that those newborn infants who received only water between nursings ultimately obtained more breast milk than those who had received complementary cow's milk feedings. Infants on six feedings ultimately received more breast milk than those put on five feedings. These reports are cited because frequently the urge to have the infant regain his birth weight by the time of discharge from the hospital leads to too ready use of cow's milk mixtures. In view of the desirability of breast feeding and the adjustments which the newborn infant must make, it would seem wiser not to turn with haste to cow's milk unless it is obvious that breast milk will not be available. Furthermore, one must remember that the caloric needs of the newborn infant are low and that it is a relatively easy matter to make him gain weight once he has made his neonatal adjustments. Consequently, the disadvantage of underfeeding is not great provided adequate fluid has been supplied. In the feeding of newborn infants the directions given to the owners of new cars, namely, to drive slowly, can well serve as a guide.

Conclusion

In closing I wish to stress several needs which must be satisfied if we are to decrease neonatal mortality and morbidity.

Although only casual reference has been made in this discussion to obstetric aspects, the first and foremost problem is to provide more and better obstetric care, including antenatal, natal and immediate postnatal supervision in order to prevent deaths due to prematurity, birth injuries, congenital lues or asphyxia.

Second, the increasing concentration of deliveries in hospitals requires closes crutiny and improvement of modern nursery practice if we are to prevent the spread of infections such as epidemic diarrhea.

Third, we must recognize that the premature infant requires special care, including segregation from other infants; control, preferably automatic, of his environmental temperature and humidity; abundant skilled nursing service, and continuous medical supervision of his feeding and general care.

Fourth, we must all become more expert in our appraisal of the newborn infant, learning when to judiciously neglect and when to vigorously treat him.

Fifth, there must be available adequate personnel and equipment to give to newborn babies the benefits of the best therapeutics. If the use of well-tried methods for resuscitation, including ready use of simple oxygen tents, are life-saving for the asphyxiated baby; if the intravenous administration of fluids and transfusions are vital for newborn babies with diarrhea and hemorrhage; if lumbar puncture will relieve the convulsions of a newborn infant with a bulging fontanelle, these measures must be used as expeditiously in the newborn infant as they are in the older subject.

Finally, broader recognition of the existence of clinical problems in the newborn infant, such as is indicated by the incorporation of the subject "neonatal pediatrics" in your program, represents a big step toward reducing neonatal mortality.

☆☆

COMING MEETINGS

April 2 — 4:30 p.m. Hartford County Medcal Association, Hunt Memorial Building, Hartford. 6:30 p.m., dinner (Hartford Club). "Endocrine Therapy"— Elmer L. Sevringhaus, Associate Professor of Medicine, University of Wisconsin Medical School.

April 4 — 4:00 p.m. New London County Medical Association, Seaside Sanatorium, Niantic. 6:30 p.m. dinner. "Diagnosis and Treatment of Head Injuries" — Walter E. Dandy, Johns Hopkins Hospital.

April 9—4:00 p.m. Fairfield County Medical Association, Stratfield Hotel, Bridgeport. 6:00 p.m. dinner. Speaker — Waldemar Kaempffert, Science Editor, New York Times.

April 18—6:00 p.m. Windham County Medical Association, Nathan Hale Hotel, Willimantic. "Rheumatic Fever" — Robert Salinger, New Haven.

April 23—1:00 p.m. Litchfield County Medical Association, Charlotte Hungerford Hospital, Torrington, luncheon. "Breast Cancer" Ernest Daland, Director of Pondville and Westfield Hospitals, Massachusetts.

April 25 — 3.00 p.m. New Haven County Medical Association, "Undercliff," Meriden. 6.30 p.m. dinner. Speaker to be announced.

May 6-9 — Medical Society of State of New York, Annual Meeting, New York City.

May 14—8:30 p.m. Fairfield County Medical Association, Pickwick Arms, Greenwich. "Modern Trends in Chemotherapy" — Francis G. Blake, New Haven.

May 14-15 — New Hampshire Medical Society, Annual Meeting, Concord, New Hampshire.

May 21-22 — Massachusetts Medical Society, Annual Meeting, Boston, Massachusetts.

May 22-23 — Connecticut State Medical Society and Connecticut Hospital Association, Annual Meetings, Hotel Bond, Hartford.

June 4-6 — Medical Society of New Jersey, Annual Meeting, Atlantic City, New Jersey.

June 5-6 — Rhode Island Medical Society, Annual Meeting, Providence, Rhode Island.

June 23-25 — Maine Medical Association, Annual Meeting, Rangeley Lakes, Maine.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

Focal Infection*†

JOHN R. PAUL, M.D.,
New Haven, Conn.

Focal infection in its broadly accepted sense is a term which was seized upon avidly by the medical profession about 25 years ago. About 15 years ago this term probably reached its heyday and the concept became so well known that it is unnecessary to define it here. All I need mention is, that during this period the idea flourished that these foci of infection caused a variety of systemic diseases, and that often the "causative" focus could be eradicated by the surgeon, thus curing the local infection and the systemic disease at one stroke. But now the question is, whether the term *focal infection* has not had its day; and whether it will go the way of other out-worn things such as *floating kidney* (once dear to the heart of both doctors and laymen). Was it a psychological, instead of a pathological entity? I for one, believe that there still are plenty of examples of focal infection in clinical medicine but they are perhaps not so common as was once thought, or so easy to excise.

If we glance at the history of the doctrine of *focal infection* we find that it came into being largely as a result of the observations of Dr. Frank Billings whose work on this subject appeared in 1912. He described cases of chronic arthritis and nephritis in which tonsillectomy seemed to bring about a favorable result. This report was received with enthusiasm, and later the general concept was broadened, — acute rheumatism, myositis, myocarditis, thyroiditis, pancreatitis, and even peptic ulcer, etc., were included in the syndrome. Bacteriologists were also consulted during this period and they too were not slow in bringing out new theories supporting the doctrine. They announced that certain streptococci, particularly the streptococcus viridans might be incriminated. An extensive bacteriological literature grew up on this subject but most of it seems rather flimsy today. Of course the reason that the medical profession liked the idea of *focal infection* was that it not only seemed to carry with it a satisfactory explanation of the cause of many diseases, which at that time (and today too) were poorly understood, but also it carried with it the hope of an easy cure by pulling out the teeth, by puncturing a sinus, or by taking out the tonsils. The tonsils were particularly appealing. But it is unnecessary to point out that the situation is not so simple and I think Dr. Billings recognized that fact too. It was the public which exploited this doctrine. Certainly *focal infection* does not seem to play the important rôle that was once attributed to it in diseases such as, for instance, myocarditis or peptic ulcer, or thyroid disease.

A good example of this changing point of view may perhaps be found in the change of attitude towards some forms of chronic arthritis. There are many varieties of chronic arthritis, but with regard to one of the commonest, — namely, atrophic (or rheumatoid) arthritis, our attitude is a little more humble than it was. Today the pathogenesis of this disease is regarded as quite obscure. It is recognized, nevertheless, that symptomatic improvement is sometimes obtained by the so-called "eradication of foci of infection" in the early stages of atrophic arthritis. But there is less evidence of such improvement once the disease is well established; once it has progressed for 5 years, let us say, there is not much benefit to be derived by pulling out functioning teeth, or by taking out tonsils. In fact the "old" arithitic often does badly if subjected to such operations, particularly mutilating operations on the sinuses and the teeth. A chronic tonsillar infection in an atrophic arthritic is not a desirable situation but the effect of this infection on the patient might perhaps be compared with the manner in which such an infection might act upon a diabetic; namely, (in the latter case) the local infection seems to make the diabetes worse; among other things it impairs the sugar tolerance. Nevertheless, again I do not have to point out that we have no illusions that by taking out the tonsils we can cure diabetes, or that we can cure atrophic arthritis by this same simple procedure. The same might also be said with regard to another very common type of arthritis, namely, hypertrophic arthritis.

---

*From the Department of Internal Medicine, Yale University School of Medicine, New Haven, Conn.

†Read at the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

Another example of this changing point of view is found in the current attitude towards rheumatic fever, and acute nephritis too. Both diseases are still poorly understood, but here the *focal infection* (if you can call it that) seems to play the part of a "*precipitating*" influence rather than that of a constant and prolonged "source of poisoning." In other words an acute attack of tonsilitis (usually caused by the hemolytic streptococcus) is often the event which seems to initiate the first attack and begin the whole long train of symptoms which we call rheumatic fever. Here again, we no longer have any illusions that we can prevent rheumatic fever by taking out the tonsils in infancy, or cure the disease by taking them out during convalescence. As a matter of fact, tonsillectomy is a dangerous procedure for rheumatic fever patients also, unless done during a quiescent phase of the disease.

But on the other hand, there are localized chronic infections; that is, true *focal infections* which can give rise to systemic symptoms. No one can deny that. Common examples are those of tuberculosis and chronic Neisserian infections. A small focus of active tuberculosis can certainly give rise to many systemic symptoms including weight loss, fatigability, and even, perhaps, joint symptoms. Chronic prostatitis, originally of gonococcal origin, also can be associated with a chronic form of arthritis giving rise to the picture which Dr. Billings had in mind 25 years ago, and there are plenty of other examples. But the point is, that these conditions I have just mentioned are not *focal infections* which can be easily eradicated surgically; on the other hand sometimes they yield to various measures such as pneumothorax in the case of a pulmonary tuberculous lesion, and to sulfanilamide in the case of gonorrhoeal infection. The thing that has happened to the concept of *focal infection* is that today it has become more of a medical problem and perhaps less of a surgical problem. Such foci should, perhaps, be searched for as vigorously as ever and this implies that a careful, even a meticulous examination, be made of all patients in whom such localized infections could play a major or minor role. It also implies a consideration as to whether the suspicious tooth or tonsil, or the sinus condition may not be the *result*, rather than the cause of the systemic disease. It also implies that *focal infections* when found, should receive the best attention that we have at our disposal but a program of treatment should be attempted slowly and carefully. The program should not anticipate easy miracles and above all it should not take the form of what is known as meddlesome therapy.

CANDIDATES FOR AMERICAN BOARD OF OPHTHALMOLOGY

The Board requirement for practical surgery is the combined extraction of a lens from a cat's eye.

Evening classes in this technic will be conducted during the last two weeks of April at The New Haven Hospital. For further information write Clement C. Clarke, M.D., 158 Whitney Ave., New Haven.

HARTFORD HOSPITAL MEDICAL CLINICS

The time for the Tuesday Clinics at the Hartford Hospital has been changed to 12 noon. It is planned to make the clinics of general interest to the physicians as practical as possible. The time was changed to 12 o'clock in order to enable some of the men with early office hours and in surrounding communities to attend the clinics and still be back in their offices in sufficient time.

The PROFESSIONAL EQUIPMENT Co.

RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.

TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

Prepaid Medical Service

CREIGHTON BARKER, M.D.,
New Haven, Conn.

In these days of changing trends in the distribution and financing of medical care two devices are most frequently proposed. One is group practice, the other is some variant of a prepayment or insurance plan. Group practice was one of the major recommendations of the Committee on the Cost of Medical Care in 1932 and is still favored by a few but interest in it as a solution for the problem of providing medical care has extended slowly while prepayment plans, allowing free choice of physicians, are springing up on every hand. The reason for the predominant interest in them is, in part anyway, because they preserve the traditional patient-physician relationship and allow the patient to employ a physician of his own choice.

Commercial insurance carriers have not entered this field to any great extent although some types of coverage are provided by them. This coverage is commonly of a straight cash indemnity nature and written in connection with other insurance, usually a small life indemnity.

Essentially all of the non-profit prepayment plans, in operation or being developed, are the same. They depend upon the simplest of insurance principles, that of collecting contributions from the mass to pay the cost of disaster for a few. Operating on that fundamental theory the plans then come into two general classifications, those providing a contract guaranteeing certain services when illness or accident occur and those providing cash indemnity in lieu of service when claims are made, with the intent that such money payments will be used to purchase the medical care required. Lately a rather ingenious combination of these two methods of indemnification has been developed.

The English and Scandinavian systems that have been in operation many years usually include wage loss indemnity along with medical care. This provision is omitted from all non-profit American plans.

Under the "contract for service" plan the underwriter agrees to give a service and may have a good deal to say about who gives that service in order that it shall be given at a price the system can afford. to pay. This tends to limit the choice of physician by the subscriber. The "cash indemnity contracts" simply pay a predetermined sum of money to the subscriber when certain events of illness occur and provide no assurance that he will be able to obtain the required professional services from the physician he chooses for the amount the underwriter pays, and on the other hand the physician has no surety that the patient will pay the money over to him for the services he has rendered. A combination of these two methods seems to be a happy solution. The underwriter agrees to pay certain sums for certain services and any physician may register with the underwriter agreeing to render those services to subscribers for the sums allowed and no more. After the services have been rendered the subscriber certifies that he has received them and the underwriter pays the physician directly in accordance with a fee schedule. It is of the greatest importance that this fee schedule be a matter of confidence between the underwriter and the physicians, otherwise there will be a gradual tendency to establish it as a standard schedule of charges for the locality when actually it may be below the average of current rates, the physicians being willing to accept less than standard fees because of the certainty of being paid promptly and in full by the underwriter.

Coverage under the many plans that are projected or operating varies widely. Some are limited to providing care only when the subscriber is hospitalized, others include ambulatory and domicilitary care and special consultation. In both instances the gross amount that may be paid to or for a subscriber is limited, most often for a contract year, sometimes for separate episodes of illness. The plans covering house and office care usually require the subscriber to pay for the first two or three visits or the first eight or ten dollars worth of service. This is to reduce the hazard of meeting frequent small claims for trivial illness. One interesting proposal is a contract to be sold for a low premium that has a fifty dollar deductable provision. That is, the first fifty dollars of any sickness cost will be borne by the subscriber; after that the under writer assumes all charges for hospitalization, and professional fees and the gross limit is high, one thousand dollars per year. There is a theory of some merit behind this project. It is that this contract at ten dollars a year may be attractive to a great number of people whose sickness costs in the past have not been high and they are willing to gamble ten dollars to be covered in a major catastrophe.

The amount the subscriber has to pay foı any of these plans is of primary importance. There is a price below which useful service cannot be provided, but the higher the cost the more limited becomes the potential market. In general the premium runs from twenty-four to thirty dollars a year for the employed subscriber for complete medical coverage, with reductions provided for the unemployed spouse and dependent minor children. A total for an average family of four would be forty to forty-five dollars annually.

Many plans establish maximum income limits for subscribers, these vary geographically but would average around $1800 for single persons to $2500 for family groups. The application of this means-test may cause administrative difficulty, for, except from payroll data, income is not readily determined.

All the public plans depend on group sale to employed workers where the payroll deduction or group collection method for premium payment can be utilized. The writing of individual contracts increases the acquisition and administration cost and the loss hazard.

A composite of the best features of more than thirty contracts minutely studied would provide

1. Group sale and payroll deduction of premium.
2. Enrollment fee of one dollar, paid once.
3. Premium for employed head of family, two dollars each month increasing to three dollars and twenty-five cents each month for a family group.
4. Medical service in home, physician's office or hospitals, a maximum of $500 per year for an individual and $800 for the family group. X-ray service to $35.00.
5. Exclusion of mental and veneral disease and tuberculosis after diagnosis; pregnancy during the first contract year; services covered by Workmen's Compensation laws and Veteran's benefits.
6. First ten dollars of cost of house or office care for each individual in family group to be paid by subscriber to the underwriter.
7. Waiting period of thirty days after issuance of contract for major surgery other than emergency.
8. Freedom from liability on the part of the underwriter in malpractice actions brought against physicians.

Another provision is offered here that has not been emphasized elsewhere, it is the payment of but fifty per cent of the charges for home and office care of unemployed spouses and minor children in whom the temptation to remain sick is greater than in employed persons where loss of income is involved.

It is desirable to have such coverage for sickness costs written in conjunction with, but separate from prepaid hospital service contracts.

None of these plans have been in operation long enough to establish any certain measure of success, although a few have built up an informative and satisfactory experience. As new ones develop there may be a tendency to be too liberal, to promise too much and charge too little. Given certain sound fundamentals, the success or failure of a plan will depend largely on the fair and understanding cooperation of the physicians working in it. The system is open to exploitation by the unscrupulous and every safeguard should be set up to avoid it.

Conversations with administrators of Plans now in operation bring to light the fact that more trouble is had with physicians than with patients.

Schonlein-Henoch's Purpura Simulating the Acute Surgical Abdomen*

JULIAN B. HERRMAN, M.D.,
New Haven, Conn.

The purpuras are commonly divided into two main groups; the thrombocytopenic or Werlhof's and the non-thrombocytopenic or Schonlein-Henoch's purpura. The Werlhof type is described as being characterized by bleeding from the gums and other mucous membranes, purpuric spots over the body and a marked diminution in the thrombocyres but no constitutional symptoms. Schonlein[1] in 1832 described a purpuric condition associated with arthritic pains which he called purpura rheumatica. The first description of a case of purpura associated with vomiting and excruciating abdominal pain was given by Wilan[2] in 1808. In 1827 Olivier d'Angers[3] gave a good account of purpura with abdominal symptoms. Many years later, in 1874, Henoch[4] reported a group of cases in which there was purpura associated with abdominal colic either with or without bleeding from the mucous membranes. This syndrome became known as purpura abdominalis or Henoch's purpura. It is now known that purpura rheumatica and purpura abdominalis are different manifestations of the same underlying condition. Squier[5] and other present day students of the subject believe that many cases of Werlhof's purpura should be considered in the same category.

The abdominal symptoms are caused by the extravasation of blood into the several coats of the viscera with the production of hematomata and oedema. While the ileum is most frequently involved the process may extend to any part of the gastro-intestinal tract. Kidney involvement with hematuria is not uncommon while the joints, most frequently the knee, become painful and swollen when the process causes serous exudates in them. The purpuric spots are the result of minute hemorrhages into the skin.

That Schonlein-Henoch's purpura is by no means an uncommon condition is revealed by the increasing number of case reports in the literature, especially those simulating the acute surgical abdomen. Unquestionably in many cases, primarily those which do not exhibit the classical signs and symptoms, the true condition remains unrecognized.

Etiology. Osler[6] in 1914 considered Henoch's purpura to be a manifestation of an anaphylactoid reaction. At that itme he stressed the fact that certain foods and drugs such as quinine and iodine might give rise to the symptoms of Henoch's purpura in sensitive individuals. More recently the theory[7] has been advanced that the phenomena associated with the condition are produced by the action of some toxin, probably histamine, on the capillary walls and on smooth muscle. It has been shown by Dale[8] that while histamine produces a constriction of the arteries it has a specific dilatory action on the capillaries associated with an increase in their permeability. Similar effects occur in peptone and anaphylactic shock and may be due to the formation of substances with histamine action. Also, poisons with a histamine-like action produce strong contraction of the smooth musculature of the intestine which may explain the colicky pain in purpura. Krogh and Harrop[9] showed that when there is a marked dilatation of the capillaries of the skin erythrocytes may pass through the walls and produce purpuric spots.

It has been suggested by Dzsinich[10] that in cases of anaphylactic and allergic reaction histamine is liberated by the cells of the sensitized organism. Since in many cases, both of children and adults, Alexander[11], Kahn[12] and others have shown that the attacks of Schonlein-Henoch's purpura have been definitely correlated with food allergies, it may be that the liberation of histamine induced by food allergens is the modus operandi in many instances. Kupper[13] feels that there is a relationship between histamine and many allergic phenomena. Squier[5] cites several cases in which he repeatedly precipitated attacks associated with abdominal pain, vomiting and purpura by having the patient ingest the known provocative food substance. Some of the attacks were associated with thrombocytopenia.

---

*Read before the New Haven Medical Society, June 7, 1939.

Recently there have been numerous reports of drugs producing thrombocytopenic purpura. Loewy[14] in 1934 described a case of thrombocytopenia due to the prolonged administration of sedormid (allyliso-propyl-acetyl-urea) in which, after recovery, thrombocytopenic purpura could be produced at will by the administration of from ½ to ¼ grain (0.25 gm.) of the drug. A similar case was reported by Peshkin and Miller[15] in which the ingestion of quinine and ergot gave rise to a thrombocytopenia. They also cite a case reported by Maritschek and Markowiz[16] in which quinine was the causative agent in the production of thrombocytopenia.

Symptoms. These fall into two main groups — articular and visceral, either of which may be associated with a variety of skin lesions. These manifestations occur singly, concomitantly or in varied sequence. Any joint, but most frequently the knee, may be involved giving rise to pain, swelling and tenderness.

Involvement of the viscera gives rise to colicky pains in the abdomen which may be generalized or localized. This may be associated with nausea, vomiting, diarrhoea, pyrexia or leucocytosis. The abdomen may be distended and rigid or there may be localized spasm. Masses caused by the infiltration of blood into the gut wall, lumen of the gut or the mesentery may be palpated. Hematemesis or melena may be present. The picture is that of an acute surgical abdomen and Poll[17], Osler[6], Sutherland[18], Fraser[19], and Burrows[20] among others have described numerous cases which were subjected to surgery only to find later that the condition was one of Schonlein-Henoch's purpura.

If the kidney is involved there may be hematuria as in the cases described by Silvestre[21], or if a clot forms in the pelvis it may give rise to renal colic which symptomatically cannot be distinguished from that due to calculus. Involvement of the uterus may cause hemorrhages which simulate local disease conditions such as hyperplastic endometritis, fibroid or cancer.

Skin Lesions. The skin manifestations are as protean as the symptoms of the disease. The classical lesion is purpuric but urticaria, erythema or pustular and papular eruptions are not uncommon. Angioneurotic oedema, erythema multiforme, erythema nodosum and erythema multiforme bullosum may be encountered. Unfortunately the skin manifestations which aid so greatly in establishing the correct diagnosis may appear late in the disease or not at all. Sometimes it is only in subsequence attacks that the lesions appear and the diagnosis is made.

One aspect of the condition which is of exceeding importance is its simulation of the acute surgical abdomen, a factor which frequently results in unnecessary surgery. The two most common surgical conditions with which it is confused are intussusception, especially in children, and appendicitis, although it may simulate many others. At operation the peritoneal cavity may be found to contain bloody fluid and the serosal coverings of the viscera show numerous punctuate hemorrhages. Occasionally blood may be found filling the lumen of the appendix as in a case described by Althausen.[22]

The signs and symptoms will be discussed more in detail later from the standpoint of differential diagnosis.

The protocols of two cases follow.

CASE I.

Mrs. J. De N. Age 41. Married, housewife.

Past History. Gravida II, Para. I. First pregnancy — full term normal delivery — died at age of four days of enlarged thymus. Second pregnancy terminated in a miscarriage at four months. Had an attack of right lower quadrant pain in Dec. 1938, which was diagnosed as appendicitis. It subsided under conservative treatment. Has had a wheezy cough for several years but x-ray of the lungs was negative. Never any bleeding from the mucous membranes.

Present Illness. Began on Feb. 8, 1939, with pain all over the abdomen which she likened to a severe stomach ache. After several hours it was more intense in the right lower quadrant and examination at this time showed tenderness all over abdomen most marked in right lower quadrant, where there was also spacticity, and some rebound tenderness over McBurney's point. There was no nausea, vomiting or pyrexia. Heart and lungs were negative. A diagnosis of appendicitis was made.

An ice bag was applied to the right lower quadrant and next morning the abdominal pain had subsided but she now complained of a sore throat. Examination of throat was negative. There was no rise in temperature. Within a few days the soreness of the throat had disappeared and she felt well for a week when she was suddenly seized with knife-like pain in the dorsolumbar spine. This persisted for three days and then completely subsided.

She was free from pain and felt well for a week when suddenly she developed an excruciating pain in the right upper quadrant and epigastrium which radiated to the back. This was accompanied by nausea and frequent vomiting especially after the ingestion of food but no hematemisis. Examination showed tenderness in right upper quadrant but no spasm or rigidity. No masses or viscera were palpable. There was no rise in temperature.

The pain and vomiting persisted for about two weeks but with diminishing intensity. At the end of this period she was free from symptoms and appeared in good health. This continued for approximately two weeks when one night she was seized with a severe pain in both lower quadrants, more severe on the left side and radiating down the anterior aspect of the left thigh. There were no urinary disturbances. Examination the next day revealed an abdomen with normal contour — no masses or viscera palpable. There was some tenderness low down in both lower quadrants. Vaginal examination revealed tenderness in both fornices but no masses. Uterus was normal in size and position. The patient was afebrile. Urine examination negative for albumin and sugar.

She was treated with hot douches and ice bag to abdomen with the gradual subsidence and disappearance of the pain in a few days.

Following this episode she felt well for about three weeks when she was suddenly seized with severe pain in the right knee. On examination there was slight swelling with considerable tenderness but no redness of the skin or signs of fluid in the joint. The next day she developed a sore throat, which persisted about three days. Two days later, April 23, 1939, purpuric spots gradually began to appear over the whole extent of the right leg from the knee to, and including, the foot. The purpuric spots persisted maximally for about ten days when they began to fade. With the appearance of purpuric spots she was put on orange juice, Vitamin C and calcium gluconate by mouth with rapid disappearance of the pain and swelling.

Laboratory Findings.

Wassermann — Negative
Tourniquet Test — Positive (Apr. 23, 1939)
Blood Examinations
April 23, 1939

R. B. C.	3,550,000	Bleeding Time	4.5 min.
Hgbn.	63%	Coagulation Time	21 min.
Color index	0.9		
W. B. C.	11,300	Fragility Test	
Polys.	59%	Hemolysis Starts	0.46%
Lymph.	38%	Complete	0.40%
Monos.	3%		
Platelets	88.000		

May 1, 1939
Platelets 260,000
Coagulation Time 5 min. 55 sec.
May 5, 1939
Platelet count 322.000
Bleeding Time 1 min. 30 sec.

Comment. This case is of interest because in three successive episodes the condition simulated three different acute surgical conditions — appendicitis, cholelithiasis and salpingitis. The characteristic joint involvement and purpuric eruption did not appear until about three months after the onset of the illness. The purpuric eruption was associated with a thrombocytopenia.

CASE II.

Miss F. L. Age 23, single, secretary.

Past History. With the exception of dysmenorrhea she had been well all her life. For the past year she noticed that strawberries and cucumbers caused an uticarial rash unassociated with other signs or symptoms. Her last menstrual period was Apr. 28, 1939. Had a severe uticarcial attack following the ingestion of cucumbers ten days prior to onset of present illness.

Present Illness. Began May 9, 1939, early in the morning with nausea and diarrhoea. Later in the morning there was vomiting followed by generalized abdominal pain which was more severe in the right lower quadrant. No melena or hematemisis. The pain grew steadily worse and she vomited again in the afternoon. Temperature at that time was 101°F. and pulse 100. Examination revealed spacticity of right lower abdomen with marked tenderness and rebound tenderness most marked over McBurney's point. There was a small maculopapular eruption on the anterior chest which faded on pressure.

Pain, which was colicky in nature, persisted the next day becoming more severe. The rash, however, had disappeared. No further diarrhoea or vomiting. That night she developed an intense lumbar backache which persisted until next day when it subsided. Pain gradually subsided until May 12 when she was entirely free from symptoms. Five days later she had an extensive macular eruption with itching which persisted for 24 hours.

Laboratory Findings.

Blood Examinations

May 10, 1939	W. B. C.	5,300
	Polys.	69%
	Lymph.	22%
	Monos.	5%
	Eosinophiles	4%

May 11, 1939
Tourniquet Test — Negative

May 11, 1939	R. B. C.	3,910,000
	Hgb.	77%
	Color Index	0.98
	Platelets	260,000
	W. B. C.	5,100
	Polys.	48%
	Lymph.	43%

	Monos.	5%
	Eosinophiles	3%
	Basophiles	1%
May 13, 1939	W. B. C.	6,100
	Polys.	58%
	Lymphos.	36%
	Monos.	3%
	Eosinophiles	2%
	Basophiles	1%
June 1, 1939	W. B. C.	7,600
	Polys.	58%
	Lymphos.	36%
	Monos.	3%
	Eosinophiles	3%
	Basophiles	0%

Comment. Although the second case gave a history of generalized abdominal pain localizing in the right lower quadrant and showed spacticity and some rigidity of the right lower abdominal muscles with rebound tenderness associated with pyrexia, the diagnosis was relatively simple. That the illness began with a diarrhoea before the onset of pain militated somewhat against an appendicitis. The history of a food allergy with an urticarial attack ten days previously, the colicky character of the pain, the slight but definite papular eruption and the eosinophilia made a diagnosis of Henoch's purpura warranted. Of interest is the increase in the white count and decrease in the eosinophiles as the condition subsided.

Discussion

Schonlein-Henoch's purpura is of more common occurrence than we realize. Because of its protean nature many cases go unrecognized or incorrectly diagnosed especially since the characteristic manifestations of arthritis and purpura may appear late in the disease or not at all. The prime requisite for recognizing the condition is to have it in mind when making a differential diagnosis, especially in abdominal conditions. "No one should operate on a child with abdominal colic until the diagnosis of the Schonlein-Henoch disease has been excluded," said Pratt.[9] That this dictum may apply equally well to adults is attested by the ever increasing number of laparotomies in cases which ultimately prove to be Schonlein-Henoch's disease.

Although the diagnosis is in many cases difficult to establish, there are many helpful clues which may be sought for and when found aid greatly in arriving at the correct conclusion.

History. A careful history as to sensitivity to foods or animal-dander, attacks of asthma, hay fever, urticaria or angioneurotic oedema will often furnish the clue necessary to put the physician on his guard. A history of a chronic wheezy cough as in Case I should be considered as possibly being on an allergic basis. Information should be sought relative to allergic phenomena in other members of the family. The past history should be carefully scrutinized for evidence of previous abdominal crises with or without acute arthritic manifestations going as far back as childhood in the case of adults. A history of similar attacks in the past, starting in childhood with long periods of intermission is suggestive. Inquiry should be made regarding the relation of attacks to the taking of drugs. As was stated above, quinine, ergot, some synthetic hypnotics such as sedormid and possibly other drugs can produce purpura with abdominal symptoms.

Onset. The exact mode of onset of the illness should be thoroughly investigated. Henoch's purpura is frequently initiated with diarrhoea as in Case II. In appendicitis diarrhoea is not a usual mode of onset. Tenesmus which is severe and persistent in intussusception is rarely found in Henoch's purpura. An attack of sore throat associated with abdominal pain as in two attacks of Case I is by no means uncommon in Henoch's purpura. Vomiting may be an early and persistent symptom as in Case I second attack and hematemesis may be present. The latter is not found in intussusception and helps to differentiate the two.

Pain. The abdominal pain in purpura is of colicky nature differing in this respect from that of appendicitis which is usually constant. It may start elsewhere in the body as in the arm or shoulder before localizing in the abdomen. It may shift from one part of the abdomen to another either during the same attack when the sequence is usually from upper to lower or it may involve different parts of the abdomen on subsequent attacks as in Case I.

Eruption. The patient should be interrogated closely in respect to transitory eruptions or ecchymotic spots which may have been entirely forgotten until recalled to his memory by questioning. An ecchymotic patch may have been considered a bruise from an unremembered encounter, or a previous small wheal or purpuric spot may be considered too inconsequential to relate unless enquired for specifically. Not only should the patient be questioned as to an eruption past or present but a meticulous search in a good light should be made. The eruption may be very circumscribed and evanescent as in Case II, therefore, repeated examinations should be made. As mentioned above the eruption may be variegated. In Case I it was purpuric; Case II papular.

Joint Involvement. While any joint may be involved, the knee is by far the most frequent. Arthritic manifestations may occur at any phase of the disease. At any time in the course of an attack the patient may complain of extreme pain in the region of the dorsolumbar spine. This was exhibited by both Case I and II. It is probably due to an acute arthritis of the spine produced by a serous exudate similar to that in the other joints.

Physical Examination. The adbomen may be normal in contour or greatly distended There may be marked tenderness with rebound tenderness and spacticity over McBurney's point as in Cases I and II. Tenderness and spacticity may be elicited over any part of the abdomen but the spacticity is generally much less than the degree of tenderness and the severity of the pain would lead one to expect. According to Poll[17] the spleen is palpable in 5% of the cases. Masses caused by the effusion of blood into the gut wall, lumen or mesentery may simulate those produced by an appendiceal abscess or intussusception. Occasionally these masses may be felt by rectum.

X-ray Examination. Certain surgical conditions which it simulates may be differentiated from Schonlein-Henoch's purpura by x-ray findings. After a barium enema, or in some cases with a flat plate, Schatzki[23] has described x-ray findings which are characteristic of intussusception. He has been able to identify the intussusceptum and the intussuscepiens in many cases. Ginsberg[24] has emphasized the importance of the flat plate with its fluid levels capped with gas which is pathognomonic of intestinal obstruction. This condition is simulated by those cases of Schonlein-Henoch's disease which exhibit a distended, tender abdomen associated with vomiting. Also a flat plate may show gas under the diaphragm which might differentiate a ruptured peptic ulcer which, as Singer[25] has shown, may be simulated by Schonlein-Henoch's purpura.

Laboratory Findings. The white count is subject to great variations. Often there is no significant change. In some cases there may be a leucopenia while in others leucocytoses of 27,000[22] or more are encountered. If there is a leucocytosis the polymorphonuclear cells may not be increased in proportion to the increase in the total number of white cells. There is frequently an eosinophilia present during the acute stage which disappears rapidly as the attack subsides. Vaughan[26] has shown that a leucopenia can be produced by feeding the proper allergen to sensitized individuals, a phenomenon which he desiginates by the term "leucopenic index." Eosinophilia and leucopenia, diminishing as the attack subsided, were manifested by Case II.

The thrombocytes are usually normal in number, but in some instances, as in Case I, they may be greatly reduced. Trimble[27] reports two cases with 60,000 and 40,000 thrombocytes respectively. Bleeding and coagulation time are generally normal although occasionally, as in Case I, the coagulation time may be prolonged.

The urine may show gross or microscopic blood and albumin. If as, occasionally happens, uraemia results from kidney oedema, the blood shows the usual nitrogen retention associated with that condition.

The stools may show gross or occult blood.

A valuable aid in establishing a diagnosis is the tourniquet test. It is not pathognomonic for purpura being present also in hyperthyroidism, hypertension, chronic nephritis, pernicious anaemia, subacute bacterial endocarditis and leucaemia. Rosenthal[28] believes that, with the rubber tourniquet, practically all the cases of purpura will show a positive reaction. Case I showed it but Case II did not. A suction method for determining capillary resistance has been devised by Dalldorf[29] which in some respects is superior to the tourniquet.

Drugs as Aids in Diagnosis. Althausen[22] has administered adrenalin and atropine in cases of Henoch's purpura with relief of the colicky pain when sedatives and analgesics failed. If, as was said, the colicky pain is due to the contractions of the gut caused by stimulation of the smooth muscles these drugs would give relief. Such a result would be quite suggestive in an obscure abdominal case.

Treatment. Since the symptomatology of Schonlein-Henoch's purpura is on the basis of decreased capillary resistence with its consequent hemorrhage, therapy, for the most part, is along lines which attempt to correct this condition. With this end in view many diverse remedial agents and procedures such as snake venom[30], calcium[31], streptococcus viridans vaccine[32] and autohemotherapy[33] have been tried to promote hemostasis. Lately there have been encouraging reports from the use of vitamins by Engelkes[34], Ainsworth[35] and Jersild[36]. In Case I vitamin C was given per os in addition to orange juice with noticeable symptomatic relief.

If, as in some cases, the condition is the result of an allergic reaction, an attempt should be made, after the acute attack has subsided, to determine the offending substance. Proper prophylaxis or desensitization may prevent subsequent attacks.

Prognosis. The prognosis as to recovery from an uncomplicated attack is excellent; however the likelihood of future episodes is considerable. A mistaken diagnosis with the consequent surgical interference or the occurrence of an acute condition as a complication naturally increase the morbidity and the mortality.

Even though the condition is correctly diagnosed as Henoch's purpura it does not exclude the possibility of an acute surgical abdomen. The mass of blood in the gut wall may act in the same manner as an intestinal polyp causing an intussusception when the gut tries to expel it. T. Gray[37] reports an interesting case in which an adult during an attack of Schonlein-Henoch's purpura developed an intussusception caused by hemorrhage into the gut wall as noted at operation. This was reduced and while convalescing he developed an acute intestinal obstruction which at a second operation was found to be due to a large hemorrhage into the gut wall causing complete occlusion of the lumen. Silberman[38], quoted by Osler[6], describes the case of a ten year old child who had purpura, arthritis, fever, colic and hemorrhage from the stomach and bowel. The child developed symptoms of an acute abdomen with peritonitis and died. At autopsy a small perforation was found in the fundus of the stomach.

Oedema of the kidney with uraemia, as a consequence of hemorrhage into the organ, is a serious complication that frequently results fatally.

Summary

1. Schonlein-Henoch's purpura is of more frequent occurrence than commonly believed.
2. Of great importance is its simulation of the acute surgical abdomen.
3. To reduce diagnostic errors it is of paramount importance always to consider the possibility of Schonlein-Henoch's purpura when confronted with an acute abdomen.
4. Criteria are given to aid in the differential diagnosis between Schonlein-Henoch's purpura and acute surgical abdominal conditions.
5. Two cases are presented which illustrate many of these diagnostic points.

BIBLIOGRAPHY

1. Schonlein, J., Allg. und Spec. Pathologie und Therapie, Frieberg. 1832.

2. Wilan, Rob't., On Cutaneous Diseases. London 1:454, 1808.

3. Olivier d'Angers, Archives Generales. 15.

4. Henoch, E. Ueber eine Eigenthumliche Form von Purpura. Berl. Klin. Wchnschr. 11:641, 1874.

5. Squier, T. L. and Madison, F. W., Thrombocytopenic Purpura Due to Food Allergy. Journ. of Allergy 8:143, 1937.

6. Osler, W., The Visceral Lesions of Purpura and Allied Conditions. Brit. Med. Jour. 1:517, 1914.

7. Pratt, J. H. in Osler's Modern Medicine (McCrae) 5:101, 1927.

8. Dale, H. H. and Richards, A. N., Vasodilator Action of Histamine and of Some Other Substances. Jour. of Physiol. 52:110, 1918.

9. Quoted by Pratt in Osler's Modern Medicine (McCrae). 5:101, 1927.

10. Dzsinich, A., Histamine in Allergic Conditions. Klin. Wchnschr. 14:1612, 1935. Abst. Jour. Allergy. 6:213, 1936.

11. Alexander, H. L. and Eyermann, C. H., Allergic Purpura. J. A. M. A. 92:2092, 1929.

12. Kahn, I. S., Henoch's Purpura Due to Food Allergy. J. Lab. and Clin. Med. 14:835, 1929.

13. Kupper, A. Histamine. Klin. Wchnschr. 9:36, 1930. Abst. Jour. Allergy. 2:202, 1930.

14. Loewy, F. E., Thrombocytopenic Hemorrhagic Purpura Due to Idiosyncrasy Toward the Hypnotic Sedormid. Lancet. 1:845, 1934.

15. Peshkin, M. Murray and Miller, Julius A., Quinine and Ergot Allergy and Thrombocytopenic Purpura. J. A. M. A. 102:1737, 1934.

16. Maritschek, M. and Markowicz, H., Hypersensitivity to Quinine with Purpura Hemorrhagica Especially in the Upper Air and Food Passages. Monatscher. F. Ohrenk. 67:410, 1913.

17. Poll, D., Erythema Cases of the Visceral Group. Jour. Mt. Sinai Hosp. 4:997, 1938.

(*Continued on Page 237*)

Association of Connecticut Tumor Clinics

Fifteenth Meeting of the Association

Held at Waterbury Hospital, Waterbury, December 13, 1939

Doctor Charles L. Larkin, Chairman

(After welcoming the delegates Doctor Larkin explained that because reports had been received by the State Tumor Committee that some of the member clinics of the Association were showing signs of disintegration it had been decided to tell how in Waterbury they have succeeded in resuscitating their dying clinic and in giving it new life and virility.)

The American College of Surgeons pointed out that the treatment of cancer is such a complex problem that, if adequate cancer service is to be available in any general hospital, a special hospital service is needed, administered by a group that is representative of the several specialities most concerned with the various phases of cancer diagnosis and management. They advised that this could be done best through the formation of cancer clinics and cancer services in general hospitals and they formulated basic minimum standards for the organization and management of these clinics.

(1) A Cancer Clinic should be an integral part of the hospital organization and as much an entity as are the departments of medicine and surgery, although representatives of these latter departments constitute an integral part of the cancer clinic.

(2) The clinic should be directed by a permanently designated group especially interested and trained in oncology.

(3) One of the group must be chosen as chairman and he must assume responsibility for the general conduct of the clinic and management of the patients, and must imbue his associates with enthusiasm.

(4) The Cancer Clinic should conduct two types of conferences: (a) weekly clinical sessions where the group is concerned with investigation and discussion of new cases, observation and specialized care of patients under treatment and follow-up of old cases; (b) mouthly or quarterly formal conferences where selected cases of cancer are presented and physicians from the community are invited. Pathological specimens, microscopc slides, records and patients should be presented. The conference is educational and it shows the advantage of group consideration.

(5) Cancer Clinics should keep complete records of all cases and should institute adequate follow-up services.

(6) Adequate x-ray equipment for diagnosis and deep therapy and at least 100 to 200 mg ns. of radium should be available for use.

Here in Waterbury, we subscribed to the aims of the American College of Surgeons, set up a cancer clinic according to the minimum requirements and held weekly clinical meetings where new and old cases were discussed, pathological specimens both macroscopic and microscopic were shown, x-ray films were visualized and surgery and deep x-ray therapy were prescribed. Post cards were sent out advertising the existence of the clinic and soliciting cases, but only an occasional new case appeared and the old ones were not very stimulating, so the attendance at the meetings dwindled to a handful of chronic cancer enthusiasts. It was quite apparent to all that the clinic was not fulfilling its main function which are: (1) to see that all cancer patients in the community are receiving prompt and adequate therapy; (2) to educate the local physicians in the prevention, early recognition and proper treatment of this disease.

When we revised our organization we were desirous of running our clinic in such a way that it would still be recognized by the American

College of Surgeons, so we hit upon the happy plan of combining the clinical sessions and the formal conference and also added a clinical-pathological conference to the program. But the most important thing we did was to turn the meeting over to the physicians whose cases were being shown and to the general practitioners in attendance, allowing them to present and discuss their cases. The cancer specialists have the privilege of adding to the discussion. The big mistake made by most clinics is that the chairman or a small group of cancer specialists dominate the proceedings and use the clinic as a rostrum to peddle their cancer knowledge. General practitioners cannot be persuaded to come to such meetings and if they do not come the purposes of the clinic are defeated.

The chairman of the tumor clinic should be a man particularly interested in this work and also one who can conduct the clinic in such a manner that his personality does not dominate the proceedings. The only way to run a successful clinic is for every man there to feel that he is an integral part of it and that he is free to take an active part in the discussion at all times and accept assignments to work up cases and review the literature on certain topics to present to the other members. The chairman should simply direct the meeting, see that order is kept, iron out any controversial discussions that may arise, and stress the fact that the clinic is being run for the welfare of the patient and not in any way to interfere with the attending physician's conduct of the case, but merely as a consulting body giving the best possible advice, which need not necessarily be followed. The chairman should also see that clinic meetings are held once a week throughout the year at a designated time and place and that they commence promptly on the hour.

One of the important cogs in the organization of our clinic is the secretary, Mrs. D. O. Burnham, whom I will call upon now to tell you how our clinic functions with little or no added cost to the running of the hospital. Mrs. Burnham herself is a volunteer worker.

Mrs. Douglass O. Burnham

As Doctor Larkin pointed out to you, one reason for the failure of some of Connecticut's tumor clinics to function properly is the lack of adequate funds to cover the necessary expenses. The Waterbury clinic was no exception to this problem. Funds were not available for clinic purposes, but this problem was solved without additional cost, except for clerical supplies, by utilizing the help already available in the hospital in other departments and by volunteer assistance.

In this hospital an average of from three to four new cases every week are historically diagnosed as cancer, which fact places our clinic among the four largest in the state, and the work involved in running it is divided and allocated to almost every department in the hospital. The administrative officers are: (1) the chairman, whose duties have already been described; (2) the pathologist, who dictates all new cases and follow-up notes, abstracts the clinical-pathological case, and shows at the clinic the microscopic lantern slides of all biopsies taken from the cases under discussion; (3) the radiologist, who demonstrates and explains in the clinic all x-rays of the cases under discussion, and remarks on the treatment of the cases by deep x-ray therapy; and (4) the medical resident, who makes up the program each week and notifies the doctors who are to present and discuss cases.

The executive workers are members of nine different departments in the hospital.

(1) The social worker serves the clinic in three important ways: (a) She makes arrangements for treatment of patients of the low-income group in the hospital or through the Out Patient Department by working through a social or a private relief agency. (b) She makes arrangements for aftercare on discharge from the hospital to insure adequate convalescence and provides for terminal care when local resources are not available. (c) Patients who fail to return for examination in response to follow-up cards or requests from their physicians are sent letters by the social worker or visits are made to the patients in their homes. In some instances the transportation of patients to the clinic must be arranged. The social worker is also beginning a new service available for staff physicians through which private cancer patients who fail to return to their doctors for treatment may be followed up and persuaded to return. By this method it is hoped that the delay between the time when the patient is first seen by the physician and the time when adequate treatment is administered may be shortened.

(2) The x-ray department records all x-ray treatments which are incorporated by the secretary into the clinic records.

(3) The record room lists all new and old cancer cases that come into the hospital and informs the secretary.

(4) The department of nurses provides a nurse to assist during clinic hours and instructs floor nurses to give tumor clinic appointment cards to ward patients on their discharge.

(5) The interns obtain certain pertinent data from the patient to be recorded on the clinic record.

(6) The dietician arranges luncheon for those who attend clinic.

(7) The dietician's secretary mimeographs the program and the abstract of the clinical-pathological case history each week.

(8) The laboratory secretary, besides recording follow-up notes, addresses and mails out the weekly program to all physicians in the vicinity.

(9) The remaining work, such as writing up new cases, sending out appointment cards, following up private cases, and numerous other details, constitutes my job as secretary of the clinic. It is also my responsibility to check up on the work of the other departments and see that it is being performed.

The yearly cost for clerical supplies since this clinic was started in 1931 has been about $15.00, and the cost for postage about $85.00, making a total of $100.00 a year. There has been some expense for new and additional equipment such as a lantern slide projector, but this has been a relatively small amount. There are other costs absorbed by the hospital and charged to the account of prestige and good will, such as lunches for those who attend clinic, photographs of lesions, association meetings, and so forth.

Our system of records appears to be functioning adequately and properly and the forms used are those recommended by the Committee on Records of the Association of Connecticut Tumor Clinics and provided by the Cancer Division of the State Department of Health. We have had considerable difficulty in obtaining some of the data required for these records and think that this might be corrected if the Record Committee of the Association could devise a standard form of hospital history sheet that will include the questions that are now so laboriously and often never obtained. The questions referred to are the following:

(1) Time elapsing between the first symptoms and the visit to the first physician.

(2) Time elapsing between the visit to the first physician and to the clinic for adequate treatment.

(3) The reason for delay.

(4) Referred to the clinic by whom.

We have had little or no trouble with our follow-up system, and credit is due to the Hartford Hospital from whom we have borrowed blanks and methods. A few words of explanation of this system might be in order. For the follow-up of private cases a printed letter is sent to every physician whose patients are registered in the tumor clinic every four months, listing their names and requesting follow-up information. The cooperation of our local physicians in responding to these letters has been most gratifying, however, if no answer is received the doctor is telephoned and permission is asked to trace his patients through the Social Service Department. For the follow-up of ward cases each patient is given an appointment by the floor nurse before being discharged from the hospital, and at the same time told about the clinic and its facilities. Subsequently, appointment cards are mailed out about three weeks in advance, followed by a printed reminder a few days before the appointment. It is believed that about 75 per cent of these patients return to the clinic for examination. If a patient does not return after two appointments have been sent, the social worker takes charge of the case and telephones or makes a call in an attempt to determine the cause of neglect and perhaps persuade the patient to return.

Doctor Larkin

Another important cog in the proper functioning of our clinic is the medical resident Doctor Elliott Mayo, who will describe his duties in regard to the tumor clinic.

Doctor Elliott R. Mayo

The part I play in the clinic routine is that of making up the program each week. This program is divided into three sections:

(1) the follow-up cases, a list of which is supplied by the secretary.

(2) the clinical-pathological conference.
(3) the study of new cases.

The clinical-pathological case is selected from the records with the cooperation of the pathologist. This case may be either new or old, and may be on either the private or public wards. The case is assigned to an interne who prepares the abstract and reads it at the clinic. A copy of this abstract has been mailed to all members of the staff three days before along with the program. This preveiw of the case history allows the physicians plenty of time for study and results in a more general and livelier discussion of the case and the general problems than would otherwise ensue. A member of the staff is notified two days before the clinic day that he is to discuss the differential diagnosis and then give the probable diagnosis, after which the case is thrown open to general discussion and further diagnoses. Finally, the pathologist reads the autopsy report and gives the pathological diagnosis.

The new cases are selected from the wards of the hospital and an interne is assigned to each case to prepare the history and read it to the clinic. The doctors whose cases are presented have been notified of the fact and are present to discuss them and to outline the treatment which has been employed or which it is planned to use. These cases are then thrown open for general discussion. When possible, the patients themselves are presented in the clinic for examination by a few staff doctors assigned by the chairman or by the whole group. If the patient is not shown it is the custom to take colored photographs of the lesion and project these on the screen.

The program is often augmented by last minute additions from the Out Patient Department or from the practices of physicians desiring help in diagnosis or in the handling of a case.

The following program has been selected for today's clinic:

1. FOLLOW-UP CASES
   a. L.C.: Chorioepithelioma of the uterus.
      G. Barrett
      J. M. Freiheit
      H. J. Corbett
   b. L.R.: Bilateral teratoma testis with embryonal carcinoma superimposed.
      R. Crane
      H. J. Stettbacher
      C. H. Neuswanger
   c. L.K.: Bowen's disease with squamous cell carcinoma superimposed.
      J. Astone
      R. J. Lawton
   d. L.McE.: Early carcinoma of the cervix.
      R. B. Nelson
      L. C. Backhus
   e. N.A.: Carcinoma of the breast.
      J. Sklaver
      A. E. Herrmann
      W. A. Goodrich

2. CLINICAL-PATHOLOGICAL CONFERENCE
      R. Crane
      E. H. Kirschbaum
      O. J. Bizzozero

3. NEW CASES
   a. F.S.: Hypernephroma of Kidney
      H. G. Atha
   b. S.H.: Dercum's disease and possible pituitary tumor.
      J. Coppetto
      C. L. Larkin
      S. M. Atkins
      W. M. Good
      T. F. Bevans
   c. A.G.: Pyonephrosis complicated by cystic right kidney
      J. Hanley
      A. E. Sirica
      H. J. Stettbacher

AUTOMOBILE ACCIDENTS ANALYZED

Highlights from the annual report, based on official records of the 48 states, include the following interesting facts:

Exceeding the speed limit was responsible for 36.5 per cent of the fatalities and 22.5 per cent of the injuries in 1939.

Nearly 40 per cent of all traffic accident victims were pedestrians.

Almost 87 per cent of the fatal accidents occurred in clear weather and almost 80 per cent happened when the road surface was dry.

More than 93 per cent of the drivers involved in fatal accidents were male and less than seven per cent female.

More persons were killed on Sunday than on any other day of the week, while the heaviest injury toll came on Saturday. Wednesday was the safest day for travel. The period between 7 p.m. and 8 p.m. was the most dangerous hour of the day.

The motor vehicle death rate, based on mileage, is at least three times as high by night as by day.

State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

Connecticut Mortality in 1939

WILLIAM C. WELLING
Hartford, Conn.

During 1939 there were 17,381 deaths of Connecticut residents within the borders of the state, as compared with 17,281 deaths in 1938, an increase of exactly 100. In 1939, 312 deaths of non-residents occurred within the state, so that the gross mortality was 17,693.

The death rate per 1,000 estimated population in 1939, for Connecticut resident deaths, was 9.6 and this is the lowest general death rate ever recorded in the state. The death rate, based on the gross mortality of 17,693 deaths, was 9.8.

Later in 1940 the Bureau of the Census in Washington will send copies of deaths of Connecticut residents occurring in other states, so that the state department of health will be enabled to follow the Connecticut mortality throughout continental United States. The exchange of such certificates is of great value in special studies of mortality, such as cancer and tuberculosis.

In the table which is given below, a comparison is made of the mortality in 1939 and 1938 for a brief list of causes of death. The figures for 1939 are provisional, and subject to slight change.

Cause of Death	1939	1938	*Increase*	*Decrease*
Typhoid fever	7	5	2	
Measles	9	1	8	
Scarlet fever	4	4		
Whooping cough	22	13	9	
Diphtheria	5	12		7
Influenza	79	78	1	
Poliomyelitis	2	0	2	
Cerebrospinal meningitis	4	3	1	
Tuberculosis, pulmonary	535	548		13
Tuberculosis, other forms	56	68		12
Cancer	2235	2432		197
Diseases of the heart	5263	4309	954	
Pneumonia Broncho	323	380		57
Pneumonia, Lobar	401	474		73
Pneumonia, Undefined	8	8		
Diarrhea under 2	34	60		26
Puerperal diseases	63	68		5
Accident	1073	1210		137
Other Causes	7258	7608		350
Totals	17381	17281	977	877
Net Increase 100				

Typhoid fever is such a rarity now in Connecticut that only 7 persons died of the disease in 1939. With a death rate of only 0.4 per 100,000 of the population, this means it would be necessary to assemble 250,000 in Connecticut on the average, to get one death from typhoid fever.

Diphtheria, however, made an even better record than typhoid fever, with only 5 deaths for 1939, and a death rate of 0.3 per 100,000 population, an all-time low record for Connecticut. Some fifteen years ago, in 1924, the diphtheria death rate was 11.2 and the typhoid rate 2.5, both rates per 100,000 population. At that time it hardly would have been considered within the realm of probability that the diphtheria rate would eventually be lower than the typhoid rate; but such has actually happened in 1939. In 1939, 41 cases of diphtheria were reported and 187 in 1938.

An increased incidence of measles cases 17,039 in 1939 as compared with 1577 in 1938, resulted in 9 deaths in the last year, whereas there was only a single death in 1938. The scarlet fever cases were 2517 in 1939 and 3129 in 1938, with 4 deaths in each year. The mortality from whooping cough resulted in 22 deaths in 1939, 13 in 1938, increase of 9. The cases were 3793 a year ago and 3512 in 1938.

In 1938 there was not a single death from poliomyelitis and 18 cases were reported in that year. For 1939 there were 2 deaths attributed to this cause and 28 cases.

The mortality from tuberculosis continued to decline in 1939. From pulmonary tuberculosis there were 535 deaths with a death rate of 29.5 per 100,000 population, the lowest death rate ever recorded. From other forms of tuberculosis, 56 deaths resulted in 1939, the rate being 3.1. The death rate for all forms of tuberculosis was 32.6, another record.

Since 1937 there has been a startling reduction in pneumonia deaths. In that year there were 1155 deaths due to all forms of pneumonia, and the death rate was 65.4. In 1938 there were 862 deaths and 732 in 1939, for all forms of pneumonia. The respective death rates are 48.2 and 40.4. It might be noted, incidentally, the mortality of 862 deaths in 1938 was first time since 1889, when there were 915 deaths due to pneumonia, that the mortality from this cause has been less than 1,000 deaths in any year.

In 1939 there was a decrease in deaths charged to cancer, but analysis reveals the fact that this decrease should be viewed with caution

In 1939 the puerperal state accounted for 63 deaths. Based on 23,106 living births, these deaths occurred at a rate of 2.7 per 1,000 living births, and this is the lowest maternal rate ever recorded, even surpassing the rate of 1937 when Connecticut had the lowest rate of any state in the Union.

Children dying in the first year of life resulted in 832 deaths in 1939, and 849 in 1938. The infant mortality rates per 1,000 living births were 36.0 and 36.3 respectively. The rate of 36.0 is the low record for Connecticut.

In 1939 diseases of the heart caused 5263 deaths, provisionally. This is 30.3 per cent of the 17,381 deaths, and is the leading cause of death in Connecticut. The death rate for 1939 is 290.6 per 100,000 population. Of course, some cause of death will always be a leading cause, except in case of ties. While the final figures for the age grouping of deaths due to heart disease in 1939 will not be available for several months, nevertheless, a rough sampling in 1939 seems to indicate that a younger age group is suffering the mortality than was the case in the past. For the leading cause of death to be attacking a younger age grouping is indeed a problem worthy of the most careful study and analysis.

TEN LEADING CAUSES OF DEATH IN CONNECTICUT

1910	Deaths	1920	Deaths	1938	Deaths
Pneumonia	1768	Pneumonia	2073	Organic Heart Disease	4309
Heart Disease	1544	Heart Disease	1817	Cancer	2432
Tuberculosis	1420	Tuberculosis	1654	Apoplexy	1486
Nephritis	1147	Influenza	1256	Acute & Chronic Nephritis	1420
Diarrhea Under 2	1085	Nephritis	1252	Accidents	1210
Cerebral Hemorrhage	955	Cerebral Hemorrhage	1443	Pneumonia	862
Cancer	894	Cancer	1399	Arteriosclerosis	755
Premature Birth	509	Diarrhea Under 2	695	Tuberculosis	616
Influenza	274	Premature Birth	694	Diabetes	509
Diphtheria	273	Diabetes	262	Diseases of Arteries	443

* * *

Adequate education of the indvidual, the community and the nation, is the keystone of a sound program to rid the country of tuberculosis. Education is the vaccine, immunizing agency and greatest prophylactic procedure against the disease. Emerson Kendall, M.D.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

148th Annual Meeting

Hotel Bond, Hartford, Wednesday, May 22, 1940

9:00 **REGISTRATION** — Main Lobby

9:30 **SCIENTIFIC SESSION,** Ballroom — Joseph I. Linde, President, Presiding.

Panel of visiting discussants:

Paul D. White, Boston
William S. McCann, Rochester, N.Y.
James C. White, Boston
Foster S. Kellogg, Boston

Increasing Incidence of Degenerative Diseases.	Walls W. Bunnell, Farmington
Symptoms Compelling Attention to the Heart.	Louis H. Nahum, New Haven
How to Evaluate the Limitations of a Patient with Cardiac Disease.	John A. Wentworth, Hartford
Fallacies and Deficiencies in Treatment of Cardiac Patients.	William J. Bruckner, New Haven

Ten minute recess

Mental Manifestations in Cardio-Reno-Vascular Disease.	Edwin F. Gildea, New Haven
Post-infectious Nephritis in Childhood.	Daniel C. Darrow, New Haven
Indications for Therapeutic Use of Intravenous Amino-acids.	Lee E. Farr, New York

11:30 **DISCUSSION BY MEMBERS OF THE PANEL.**

Choice of Anesthesia in the Presence of Peripheral Vascular Disease.
Management of Pregnancy Associated with Cardiac Disease.
The Use of Graduated Exercise in Cardiac Disease.
Accepted Classification of the Toxemias of Pregnancy.

Question Period

1:30 **SECTION LUNCHEONS.** Members and guests may lunch with any section or at tables reserved in the main dining room.

2:30 **SECTION MEETINGS** — open to all.

ANESTHESIA — Old English Room, Ralph M. Tovell, presiding.

Choice of Anesthesia	Meyer Saklad, Providence
Survey of the Anesthesia Service at Grasslands Hospital, 1938 to 1940	Harold F. Bishop, Valhalla, N.Y.
Anesthesia in Relation to Cardiac Disease.	L. Corsan Reid, New York
The Injection of Procaine and Alcohol in the Diagnosis and Treatment of Intractable Visceral Pain.	James C. White, Boston

DERMATOLOGY AND SYPHILOLOGY — Egyptian Room, Michael J. Morrisey, Presiding.

William S. McCann will be the guest of this Section.

Problems in the Treatment of Early Syphilis.	Allan K. Poole, New Haven

INDUSTRIAL MEDICINE — Room 7, Clifford Kuh, Chairman. Organization Meeting.

ORTHOPEDICS — Ballroom, J. Leonard Vickers, presiding.

Modern Treatment of Low Back Pain and Sciatica.	Philip D. Wilson, New York

HEZEKIAH BEARDSLEY PEDIATRIC CLUB — Moorish Room, Oliver L. Stringfield, presiding.

Paul D. White will be the guest of this Section

The Preventive Aspects of Heart Disease in Children.	Katherine G. Dodge, New York
Congenital Urological Anomalies.	Chris. H. Neuswanger, Waterbury

WOMEN'S MEDICAL SOCIETY — Room 6, Edith A. MacLeod, presiding.

Foster S. Kellogg will be the guest of the Society.

THE CONNECTICUT HOSPITAL ASSOCIATION — Modernistic Room, Wilmar M. Allen, presiding.

Hospital Public Relations. (Speaker to be announced)
Round Table Discussions.

MEDICAL RECORD LIBRARIANS

9:00 Registration. Business Meeting, Harriet Lyman, presiding.
2:00 Round Table Conference, Grace Gillespie, presiding.

1. Reasons for being a member of the national and local association and for being registered. 2. Tumor clinic and tumor clinical records. Explanation of classification used in tumor clinics throughout the State. 3. Demonstration of punch card system for recording diagnosis and operations. 4. The growing demand for information for hospital plans and what to do about it. 5. Recordat, method of photographing histories to conserve time and space. 6. History taking and form filling in relation to insurance. 7. Status of the ordinary medical record as a legal document. 8. Demonstrations of Soundex, Kardex, and housing for such records. 9. Nomenclature problems.

7:30 **ANNUAL DINNER: THE CONNECTICUT STATE MEDICAL SOCIETY** — Ballroom.

Speaker: Haven Emerson, New York.

148th Annual Meeting

Hotel Bond, Hartford, Thursday, May 23, 1940

9:00 **REGISTRATION**—Main Lobby

9:30 **SCIENTIFIC SESSION**—Ballroom—A. Nowell Creadick, Chairman Program Committee presiding.

Panel of visiting discussants:

T. Grier Miller, Philadelphia
George P. Muller, Philadelphia
Louis E. Phaneuf, Boston
Albert D. Rudemann, Cleveland.

Manifestations of Nervous and Mental Disease—Referable to the Gastro-intestinal Tract.	Benjamin V. White, Hartford
Character Physique and the Gastro-intestinal Tract	George A. Gosselin, Hartford
Neurologic Lesions that give Gastric Symptoms.	James C. Fox, Jr., New Haven
Eye and Ear Lesions with Gastric Symptoms.	Shirley H. Baron, New London
Tumors of the Gastro-intestinal Tract.	Ashley W. Oughterson, New Haven

Ten minute recess

Diagnosis by Gastroscopy	Samuel D. Kushlan, New Haven
The Necessity for Rectal-Signoidal Examinations in Routine Physical Examinations.	Simon B. Kleiner, New Haven
Ruptured Ovarian Follicles Simulating Appendicitis.	Floyd A. Weed, Torrington
The Significance of Pelvic Pain in Gynecological Conditions.	Arthur H. Morse, New Haven

11:30 **DISCUSSION BY MEMBERS OF THE PANEL.**

Question Period

1:30 **PRESIDENT'S LUNCHEON**—Ballroom
Presentation of Incoming President—Arthur B. Landry
Address of Retiring President — Joseph I. Linde

3:30 **SECTION MEETINGS** — open to all

EYE, EAR, NOSE AND THROAT — Egyptian Room, Shirley H. Baron, presiding.

End Results of Eye Muscle Surgery	Albert D. Rudemann, Cleveland
Difficulties in Interpretation of Nasal Accessory Roentgenograms.	Frederick M. Law, New York
An Analysis of Fundus Changes in Sinus Thrombosis.	Isidore Friesner, New York

NEUROLOGY AND PSYCHIATRY — Moorish Room, Chester Waterman, presiding.

Progress in Hormone Therapy of the Psychoses.	Marjorie B. Patterson, Hartford

OBSTETRICS AND GYNECOLOGY — Ballroom, Emerson L. Stone, presiding.

Manchester Operation in the Treatment of Uterine Prolapse.	Louis E. Phaneuf, Boston

PHYSIOTHERAPY — Modernistic Room, Harry E. Stewart, presiding.

Treatment of Subacromical Bursitis.	Alexander L. Bassin, New Haven

PROCTOLOGY — Room 7, Simon B. Kleiner, presiding.

George P. Muller will be the guest of this Section.

The Role of Radiation Therapy in Treatment of Rectal Cancer	George E. Binkley, New York

RADIOLOGY — Old English Room, Samuel M. Atkins, presiding.

T. Grier Miller will be the guest of this Section.

The Roentgenological Examination in Hemorrhage from the Upper Gastro-intestinal Tract.	Richard Schatzki, Boston

CONNECTICUT OCCUPATIONAL THERAPY SOCIETY — Room 8, Harry Kromer, presiding.

Community Program	Benjamin G. Horning, Hartford

An Exhibit of Occupational Therapy in Connecticut.

CONNECTICUT BRANCH, AMERICAN MEDICAL SOCIAL WORKERS—Room 6, Ellen Ogren, presiding.

A Presentation of a Medical-social Case History Showing the Relationship of Medicine and Medical Social Service.

7:00 **SECTION DINNERS**

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief,*	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Stamford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

CHEMOTHERAPY WITH THE SULFONAMIDE DERIVATIVES

Following the introduction of the sulfonamide compounds as bacterial chemotherapeutic agents, the use of these drugs became very soon so apparently successful that they were widely used clinically before much was known concerning the scope of their chemotherapeutic properties in experimental infections, their mechanism of action, their toxicity, and the principles governing their absorption, distribution, conjugation and excretion. Numerous compunds appeared in rapid succession under a variety of names with conflicting claims concerning their relative merits. Gradually, however, careful laboratory investigations began to parallel and influence clinical application, until latterly they have begun quite properly to precede the introduction of new compounds, prepared with the purpose of extending the usefulness of the sulfonamide derivatives in human disease.

The sulfonamide derivatives center around para-amino-benzene sulfonamide, which now bears the medical designation, sulfanilamide. They may be conveniently placed in two groups. The first group, which includes the original prontosil used by Domagk, consists of those derivatives in which substitutions have been made in the para-amino NH_2 group; the second, of those in which substitutions have been made in the sulfonamide SO_2NH_2 group at the other end of the benzene ring leaving the para-amino group free. Among the latter may be mentioned sulfapyridine and sulfathiazole, the latter recently introduced and now being submitted to experimental investigation in the laboratory and the clinic.

Comparative studies in animals on the protective action of the sulfonamide compounds and *in vitro* observations on their bacteriostatic properties have covered a wide range of bacteria and viruses. At first glance the results reported often appear conflicting, no doubt due to numerous variables which occur in experiments of this kind before a standard technique has been evolved. In spite of this, certain high lights stand out, which may serve to bring some degree of order out of the apparent confusion, even though many points still remain at issue.

The first significant experimental observations were, of course, those of Domagk, that the azo dyes, prontosil and neoprontosil, though exerting no demonstrable bacteriostatic action *in vitro*, were nevertheless effective *in vivo* against virulent hemolytic streptococci. The second highly important contribution was that of the Trefouels, who showed that sulfanilamide by itself without the azo linkage was not only effective against hemolytic streptococcal infections in mice but also possessed active bacteriostatic properties *in vitro*. These observations provided the basis for the now widely accepted view that the first group of compounds are changed in the animal body and owe the major portion of their activity to the liberation of sulfanilamide. If this be correct, sulfanilamide weight for weight should be more effective than prontosil or neoprontosil, provided variations in absorption are not so great as to render comparisons invalid. Though the pitfalls in such comparisons are numerous and there is not complete agreement, it would, nevertheless, appear that the majority of workers have recorded experiments indicating that this is so, not only with hemolytic streptococci but also in the case of at least some other bacteria.

In the second group of compounds, on the other hand, are found derivatives which are at least equivalent to, if not superior to, sulfanilamide in experimental streptococcal and meningococcal infections. At the same time the scope of their effectiveness appears to be wider. Conspicuous among these is sulfapyridine, the superiority of which in pneumococcal infections is already well established.

Whether the differences exhibited indicate actual qualitative differences in specificity for different organisms or are merely quantitative, is perhaps impossible to answer with certainty at present. The much greater effectiveness of sulfapyridine against the pneumococcus would suggest specificity, but since there is some evidence that it is also more effective against hemolytic streptococci, staphylococci, and Friedlander's bacilli, for example, it would seem more likely that the difference is quantitative.

Whatever the ultimate solution of the foregoing problems may be, the clinical significance of these comparative *in vivo* and *in vitro* studies of the sulfonamide derivatives against various bacteria is obvious, since they point the way to the selection of the most effective drugs among the various compounds available. Futhermore, they suggest at least that the road to further improvement in scope and effectiveness of action lies along the way of substitutions in the sulfonamide group.

It hardly need be pointed out, however, that other factors besides relative chemotherapeutic efficiency in mice and bacteriostatic activity in the test tube may of necessity modify the selection of the most suitable drug for practical therapeutics in man, such factors as primary toxicity, absorbability, and human idiosyncrasy to untoward reactions, to mention a few.

Pharmacological studies, conspicuously those of Marshall and his collaborators, have contributed much of value to the practical application of chemotherapy in man, particularly with respect to problems of absorption, distribution in the body, conjugation to the inactive acetyl derivatives, and excretion. They have had an especially useful bearing on amount and spacing of dosage in relation to establishment and maintenance of adequate blood levels. On the other hand, clinical observations and experience have been more fruitful in defining the immediate toxic and other untoward reactions encountered in man.

Complete familiarity with all of these problems in the case of each compound is essential for the intelligent clinical use of the sulfonamide derivatives since they vary considerably from compound to compound. In the end carefully controlled studies in patients, so well illustrated by the studies of the last year on sulfapyridine in lobar pneumonia, must determine the issue in favor of this or that derivative in any given infection.

F. G. B.

* * * *

IN RESTRAINT OF TRADE

The bewildered etymologist turns to Webster's Dictionary and under "trade" finds: "5a. The business which a person has learned, and which he engages in, for livelihood and profit; occupation; especially mechanical employment as distinguished from the liberal arts, the *learned professions,* (medicine?) and agriculture (italics ours)."

The Appellate Court's resuscitation of what we hoped was a dead horse, the criminal indictment against the A.M.A. et al. brought us to with a start, for we found, and even though we sound silly, we must say it, that the everyday definition of a word (mirabile dictu) is not really suitable for every day! Our authority the New York Times for March 6, 1940, had this to say (we quote a portion of an editorial): "The Appellate Court finds that the lower court erred in giving the words "restraint of trade" their everyday meaning." Weakly we can only retort that a definition a day will certainly keep the doctor at bay.

Naively, we had been under the impression that what the doctor did for a living did not come under the same heading as what the butcher, the baker or the candlestick maker did for his living. This useful trio, respected followers of a trade, probably were a little surprised to find themselves "in trade" with old Doctor Whosit. Nay, more than surprised, offended to be classed with such a notoriously unbusiness-like group.

Going further into the realm of definition, we meet with what seems to us a fine piece of specious reasoning. It being difficult to make synonomous the words "trade" and "profession," the legal wizards of the government, nimble-footed as adagio dancers, say words to this effect: "Certainly, the practice of medicine is not in popular usage constantly called a 'trade,' but that is beside the point. The term whose meaning is in question is 'restraint of trade.' That is a legal idiom, not a term of common lay usage. Viewed in the light of the common law and the evils against which the statute was directed, there can be no question that it covers restraint upon a doctor in pursuit of his calling."

To this we say that Sherman never dreamed that his Anti-trust Law would be applied to the profession and never intended that it should. Laws try to say what they mean and no framer of laws phrases them in idiom, legal or otherwise, if he can possibly avoid it. Idioms can, however, be read into laws for the sake of expediency.

Granted that medicine is in the need of some readjustments, we wonder if the learned and academic Mr. Arnold is the man to do it.

We wonder also, in what ivy-covered walls he learned the discouraging doctrine that the means justify the end — in what cloistered halls and from what legal tome did he acquire the idea that if there is no law, one may be altered to fit?

It would appear to us, perhaps from a too casual examination of the facts, that the charge against medicine would assuredly stick, if medicine were what Mr. Arnold would like to make it — a business, with hired hands, regular hours and regular pay. Mr. Arnold would perhaps have it attractively packaged and dated to insure freshness. He would, perhaps, have us swap the Oath of Hippocrates for a neat little slogan: "We aim to please. If you like us, tell your friends, if you don't, tell us."

We fell a little depressed and, if the truth were known, a little bit frightened. We were sure it couldn't possibly happen here. But now we are plagued with uncertainty.

Any day, now, the caduceus may adorn a time clock and with this sad thought we turn to something the currently popular, old Chinese philosopher might have but did not say — "Confucius say, man who not know difference between trading and treating should return to school."

* * * *

IT CAN HAPPEN HERE

Anyone who wants to know the hocus pocus and cumbersome bureaucracy of sickness insurance should take the time to read Bill Number 2050 introduced into the Assembly of the State of New York by Mr. Robert F. Wagner, Jr. on February 28th. An entire evening had better be set aside for its perusal for the Bill is 54 pages long and replete with details. Mr. Wagner still relies upon the deceptive magic of the term "health" insurance and the title of the Bill is "To Provide For the Establishment and Administration of a System of Health Insurance."

Under the Bill participation will be compulsory for all persons with an annual income not exceeding $1500 or a weekly wage of not more than $35.00, except all agricultural labor and domestic servants when less than three are employed. Minors in part-time employment and attending school are also excepted. Whether these exceptions are made because it is expected that these people will not be sick or whether they are not exposed to the collection of taxes is not made clear.

Voluntary coverage under certain restrictions including a health examination is provided for any resident of the State whose net income from any source is $30.00 a week or less, who has not reached his 65th birthday, and any resident of the State whose net income from whatever source does not exceed $50.00 a week.

The system will give insured persons and their dependents ordinary medical care wherever rendered by a general practitioner for a period of 26 weeks, including immunization and periodic physical examinations; the services of a specialist consultant when prescribed by the general practitioner; hospitalization when prescribed; dental care; and, subject to limitations of the administering board, drugs, medicines, surgical and dental appliances, and institutional care for convalescents. Weekly cash benefits varying from $6.00 to $16.00 will be paid during the period of disability after seven days. Maternity care is provided, including a cash benefit if the mother is not gainfully employed and if prenatal care is received as prescribed by the board, a cash allowance of $15.00 will be made to the mother on the birth of her child.

To finance the system compulsory payroll deductions and employer and State contributions totalling from $1.10 to $1.20 weekly per individual will be collected. Payments from employees and employers will be made by the purchase of stamps. With commendable candor it is pointed out in a footnote to the Bill that it is contemplated that the federal government through grants-in-aid will reimburse the State for one-half of the required payments.

Administration is provided in the State Department of Health through a Health Insurance Commissioner who is not required to be a physician, and a commission of thirteen of which only three shall be physicians, including two general practitioners and one specialist. This board shall have power to make regulations governing the system, appoint district medical officers and supervisors and collect the tax.

It appears that payment to physicians and others will be left to the discretion of the administrative board as will also the qualifications of physicians and the standards of care.

Sub-Section 18, nearly at the end of the Bill is of interest:

"Federal Cooperation. 1. The board is hereby designated as the agency of the State to administer and expend any and all grants of money allocated or made available to the State under any federal act for grants-in-aid for health insurance or for any of the purposes of this act. The board is hereby authorized to do any and all things, not inconsistent with law, necessary to meet the requirements of the said federal act."

Thus do coming events cast their light shadow.

C. B.

* * * *

THE LATE-SEASON COLD

The season for the most severe upper respiratory infections with their attendant sequellae continues for a few more weeks. Those patients who during the winter are subject to repeated head colds and consequent disability need careful attention and strict adherence to the known principles for rapid recovery. The end of the winter season is always accompanied by some type of constitutional inability to eliminate infection quickly. Because of this, the normal protective mechanism should have the utmost support to subdue the offending bacterial invaders.

The human body is ever on the defense and has its own and very effective means of combat. When infection attacks the tissues, the response is known to be a congestion due to increased blood supply and accumulation of the phagocytic cells of the reticulo-endothelial system. This activity at the site of infection frequently gives annoying symptoms of obstruction to the nasal passageway. There are many who would treat the patient at this time in an attempt to reduce this congestion. The body then must reestablish the congestion to concentrate the reparative mechanism upon this infection before it can continue with the later phases of recovery. A delay or thwarting of this natural process of congestion then gives the bacterial invaders a firmer hold and the infectious process is thereby needlessly prolonged. It then follows that the nasopharyngeal tissues must overcome the effect of the treatment as well as the underlying infection. Fortunately most people have enough reserve to accomplish this, but there are those who have so little reserve at this time of year that it must not be wasted.

When we consider that the course of nature's process for recovery from infection is a definite sequence of events, congestion is to be favored instead of avoided. In acute infections nasal congestion, shrinking of the mucosa and nose-opening methods of treatment should be scrupulously avoided. Rest, which has always been a most important factor in the recovery from infection, should be advised. Symptomatic treatment should be confined to the use of methods which will not interfere with the normal process of recovery. The use of heat to the part affected, antipyretics, sedatives and analgesics are preferable to any type of local treatment to the infected mucous membrane.

The responsibility of the physician does not disappear when acute infection subsides. Other factors beside infecting organisms should be considered. Underlying sensitive mucous membranes, nasal deformities and chronically infected tonsils should receive due consideration during the warmer months to prepare for the inevitable inclement weather and the repetition of attacks by pathogenic bacteria.

N. C.

* * * *

RADIO CURE-ALLS

"We pause for special announcement by the sponsors of this program."——

"During this season of bronchial colds, sore throats and pneumonia, use E-Z-Q nose drops and get instant relief from that tight congested feeling in the head, so often the forerunner of days of incapacitating illness."

How often the strains of "Oh Johnnie, oh Johnnie" give place to the interpolation of some such blatant boon as the above! Yes, we even make the mental hurdle in a few seconds from "Rhapsody in Blue" to such an inharmonious interruption with little more reaction than a rising desire to end that cooing voice with a well delivered knockout blow in the first round. But still it goes on!

Pink pills, tasty tonics, luscious laxatives, the whole gamut of commercialized drug propaganda dispels the delightful restfulness of an enjoyable musical program!

To date, with the jurisdiction over advertising vested in the Federal Trade Commission, very little has been or can be accomplished to catch up with distasteful and misleading radio publicity of patent nostrums. Several reasons account for this state of affairs. The Federal Trade Commission is a political organization with its officials and employees politically appointed and not employees of Civil Service. The procedure under which the Federal Trade Commission operates is inadequate. It discovers violations and then through a Cease and Desist Order of a specific nature it attempts to put a stop to the particular false and misleading advertising which it has found objectionable.

The advertiser is always one step ahead of the Commission and quickly changes his advertising copy with the change in seasons before the Cease and Desist Order can overtake him. It costs the U. S. Government $100,000 to prosecute a single case of falsification of claims in advertising. Even with injunction and criminal provisions now added to the Wheeler-Lea Amendment, misleading advertising over the air goes merrily on.

It took the tragedy of Elixir Sulfaniliamide with its 105 deaths, and the Rex incident in which a number of lives were lost due to contamination of a drug with tetanus toxin, to arouse the public opinion sufficiently so that Congress passed the Food, Drug and Cosmetic Act of June 25, 1938. This Act became effective in June 1939, with new labelling provisions and certain other requirements effective January 1, 1940. It removed the necessity of establishing fraud, a serious handicap under the old law. The Act is designed to protect the public against dangerous drugs, devices and cosmetics and to define and maintain certain standards for foods. During this past December drug and medicinal product seizures involved five patent medicines, actions being based on charges of false and fraudulent claims in their labelling. 96 packages of "Dark Eyes", 56 packages of "Magic Di-Stik," and 18 packages of "Mary Luckie Lash and Brow Dye" (all eyelash dyes) were seized; also 492 cartons of "Volz Anti-Rheumin," containing the dangerous drug cincophen.

The pernicious practice of advertising all the various kinds of bunkum manufactured will go on and become as endless as Amos and Andy et al unless public opinion demands a change.

The physicians of our country are becoming aroused, as evidenced by the effective and increasing opposition to the Wagner bill. How long shall we permit the radio to peddle such uncontrolled therapeutic propaganda without raising a united voice in opposition?

* * * *

THE HEALTH OFFICER OF TODAY

It is a significant fact that New England may claim priority among American universities for the systematic education of physicians in preventive medicine and public health. The first full-time department for medical instruction in this field at Harvard in 1909 was followed shortly by the establishment of the Harvard-Technology School for Health Officers and the training of personnel for these responsibilities. From this small beginning not so long ago has come the present nationwide program which in recent years has trained more than 1500 persons annually for the responsibilities of the medical health officer, the epidemiologist, the specialist in maternal and child care, and related subjects like public health nursing and sanitary engineering.

Although it is widely accepted in most parts of the United States and in all of the Dominion of Canada that the medical degree is a prerequisite as a qualification for the important post of health officer, there are still some areas in New England and in Pennsylvania and New Jersey where non-medical men serve in this capacity. It must be said that some of the better trained among these men have served well, considering the trend toward strictly medical tasks for the health officer which now include the control of syphilis, tuberculosis, cancer and the complications of childbirth, in addition to the control of the water and milk supplies.

As a sign of the times, however, it is pertinent to note that the American Public Health Association has now declared it to be virtually necessary for a health officer to be a graduate in medicine.* Beside his fundamental training in the sciences or the humanities at least equivalent to that required for a college degree in arts or science, he must have completed the course leading to the degree of Doctor of Medicine in a recognized medical school and should have had at least one year of internship in an approved general hospital, including a communicable disease service. The Association recommends that after this training he should have a preliminary period of supervised field experience in a well organized department of health for a period sufficient to give him acquaintance with the general aspects of public health and to give him opportunity to determine something of his own liking for the work and his fitness for it. Following this training, the candidate should receive at least one full academic year of graduate instruction in public health in a university, and even then should have extended practical experience in a subordinate position before himself becoming responsible for the conduct of the work of a department of health.

Time marches on, and this recognition by the professional society of public health workers in North America is a wholesome sign of the basic place of medical training in the preparation of the health officer. Public health is a medical specialty.

*The Educational Qualifications of Health Officers, A.P.H.A., New York, 1940.

* * * *

THE HANDBOOK ON CANCER

Since 1933 the Connecticut State Medical Society has played an active role in the great problem of the diagnosis and treatment of cancer in this State. At that time a tumor committee was appointed within the Society for the purpose of surveying the entire problem in Connecticut and to stimulate interest in the movement for cancer control.

Two years later the State Medical Society sponsored a bill to establish a Division of Cancer Research within the State Department of Health. The bill was passed by the General Assembly and signed by his Excellency, the Governor. This bill authorized the State Department of Health "to make investigations concerning cancer, the prevention and treatment thereof and the mortality therefrom and to take such action as it may deem will assist in bringing about a reduction in the mortality due thereto."

Now, seven years after the initiation of activity within the State Medical Society on behalf of the cancer problem and five years after enactment of enabling legislation, another milestone has been reached. The Tumor Committee of the State Medical Society in cooperation with the State Department of Health has placed in the hands of the physicians of this State a Cancer Handbook to enable the physician to understand the problem better and to plan for his patient the most acceptable and efficaceous form of treatment. Cancer is receiving more widespread attention throughout the United States. Mortality figures are still too high. Radium and deep roentgen irradiation have increased the scope of treatment.

In very few other states have there appeared a cancer handbook as inclusive and valuable as the one just published in this State. The Medical Societies of California, Massachusetts and Iowa have published similar useful volumes.

It is the aim of the Tumor Committee of the State Medical Society to encourage our physicians to study the Handbook, refer to it frequently and follow its therapeutic suggestions. It offers in a condensed form the consummate opinion of our own experts in all fields where cancer is to be found. Details of treatment may change from year to year but the fundamental principles of early diagnosis and intensive therapy are constant, and must be followed if there is to be any solution to the problem of cancer control.

* * * *

THE UNITED STATES PHARMACOPEIAL CONVENTION

On May 14 the Convention for the Revision of the United States Pharmacopeia will meet in Washington. This decennial gathering provided for under the Constitution decides the principles under which the Pharmacopeia is to undergo revision. It also elects the officers of the Convention, a Board of Trustees to manage administration, legal and financial matters, and a Committee of Revision, all to serve until the next Revision Convention meets.

Under the Federal Food, Drug, and Cosmetic Act the standards of strength, quality and purity laid down in the Pharmacopeia for the drugs and preparations that it recognizes become the legal standards for such drugs and preparations.

As a consequence the manufacturer, the dispensing pharmacist and the physician have a common interest in the Pharmacopeia. The manufacturer is enabled to furnish the pharmacist with officially standardized materials, the pharmacist to dispense, with exactitude, just what the physician desires, and the physician to write his prescriptions in simple terms with confidence in what the pharmacist will dispense. Without the Pharmacopeia there would be chaos. Without confidence in its sponsors the situation would be perilous.

Representing the Connecticut State Medical Society at this Convention will be John H. Foster, Waterbury; Louis H. Nahum, New Haven; John A. Wentworth, Hartford.

* * * *

The Connecticut Fracture Committee will hold its Spring meeting at the Hunt Memorial Building, Hartford, April 25. Business meeting at 10:00 A.M., Round Table Forum from 11:00 to 12:30, and clinical program in the afternoon

* * * *

DOCTOR DANDY TO SPEAK AT NIANTIC

Walter E. Dandy, M.D., Professor of Surgery at Johns Hopkins University Medical School, will be the guest speaker at the New London County Medical Association annual meeting to be held at Seaside Sanatorium, Niantic, on Thursday, April 4 at 4:00 p.m. His subject will be "Diagnosis and Treatment of Head Injuries." Dinner will be served at 6:30 p.m. All physicians are cordially invited to attend.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

Conference of County Secretaries

The Secretaries of the County Associations attended a conference at the State office on February 23rd. There were present, the Secretary of Hartford County, Frank T. Oberg; of Litchfield County, W. Bradford Walker; of Middlesex County, Charles Russman; of New Haven County, Ralph E. McDonnell; of Windham County, Ralph L. Gilman, the President of the Society, the President-Elect, the Chairman of the Council, the Treasurer, the Editor of the Journal and the Executive Secretary. Absent were the Secretary of New London County, Carl H. Wies; of Fairfield County, J. Grady Booe; of Tolland County, Francis H. Burke. Doctor Linde presided. Following is the program for the conference:

1. Future progress.
   Arthur B. Landry, M.D., President-Elect
2. Discussion of collection of dues and accounting.
   James R. Miller, M.D., Treasurer
3. Discussion of plans to obtain new members.
   Creighton Barker, M.D., Executive Secretary
4. County Associations in the State Journal, Stanley B. Weld, M.D., Editor of the Journal

The address presented by the President-Elect, Doctor Landry, is printed in full elsewhere in this issue of the Journal and merits consideration of every member of the Society. As the field of activity of the Society is broadened the importance of the County Secretaries in the organization is increased and their duties and responsibilities multiplied. This is especially true in connection with the Society's finances and Doctor Miller, in his remarks at the conference, clearly set forth what those responsibilities are. A better understanding of the financial and accounting relationship between the County organizations and the State Society resulted.

In discussing the subject of new members for the Society the Executive Secretary remarked that there had for years been a mechanism for keeping members out of the Society but no method for getting them in. If the Society is to reach its maximum effectiveness, it is essential that every eligible physician in the State be on its rolls.

Doctor Weld discussed the importance of intimate contact between the County Associations and the State Journal.

Council Meeting

The Council held its regular monthly meeting on March 6th.

Present were:

James D. Gold, Chairman, Fairfield County
Edward J. Whalen, Hartford County
Charles H. Turkington, Litchfield County
Roy L. Leak, Middlesex County
Thomas P. Murdock, New Haven County
George H. Gildersleeve, New London County
Joseph I. Linde, President
Arthur B. Landry, President-Elect
James R. Miller, Treasurer
Stanley B. Weld, Editor of the Journal
Creighton Barker, Executive Secretary

Action was taken on the recommendations to be presented to the House of Delegates at its annual meeting in May, concerning an amendment to the By-Laws to exempt members of long standing from further payment of dues, and a recommendation to the House of Delegates concerning the committee organization that will be set up for the planning and direction of the 150th anniversary of the Society in 1942.

The Treasurer presented for discussion the important subject of supervision of the Society's finances and auditing of its accounts. Several methods of improved procedure were suggested and finally the Treasurer was directed to proceed with the development and installation of a system of financial control that would adequately meet the Society's requirements.

Nomination of officers and committees for the year 1940-1941 occupied the Council until a late hour.

Connecticut Hospital Association

BRIDGEPORT HOSPITAL

Mr. Bartine's Annual Report

In his annual report presented to the Board of Directors on February 15, Mr. Oliver Bartine, Superintendent of Bridgeport Hospital, gave some very interesting data regarding the operation of that institution during the year. He shows an operating income of $498,685 with expenses of $583,000, and a deficit of over $87,000, including a depreciation item on equipment, with income from Community Chest grant, Connecticut grant, and interest on invested funds sufficient to meet the deficit.

His per diem cost for the year was $5.04. He emphasizes particularly the improvement made in collections due to a more carefully worked-out collection system. The daily cost of raw food per individual was 36 cents, which shows a carefully supervised Dietary Department. There were nearly 11,000 patients admitted, with 116,000 days of service, of which 62.3% were for paid and part-paid service, and 37.7% were for free service. In this very detailed report he gives complete statistics of his institution for the year, which includes a report of 1507 new-born babies — a very active service indeed. A Department of Social Service was established at the Bridgeport Hospital on March 20, 1939, and it has been of great value in aiding to solve the problems arising in the care of patients. As do most other hospitals throughout the state, Mr. Bartine indicates a need of further expansion in various departments of the institution.

It is interesting to note in his report that Occupational Therapy is carried on under the direction of the Junior League. Another item of interest is the cooperation of the Bridgeport City Library, an employee of which visits the hospital twice each week and supplies reading matter to the patients. He also reports four legacies, amounting to $58,000 — a very substantial sum in these present days.

Attached to this report, Mr. Bartine presents a paper of comparative statistics from 1899 to 1939, showing the tremendous advances in the occupancy of the hospital during those forty years. We present here his figures by ten-year periods.

Year	*Total No. Patients Admitted*	*Average Daily Census*	*Average Stay In Hospital*	*Cost Per Patient Per Day*
1899	702	66	34	$ 1.32
1909	1460	103	24	1.61
1919	5469	200	11.3	4.51
1929	8569	275.1	13	2.83
1939	10583	318.7	10.7	5.04

In addition to the increase in the number of patients, two other items are of particular interest in this report: first, the startling decrease in the average length of stay; and secondly, the increase in the cost of caring for patients.

Mr. Bartine is to be congratulated in presenting such a very thorough report of his hospital.

* * * *

PUBLIC RELATIONS

It is interesting to note the wide-spread development of hospital news organs. In recent issues of the Lewis Manufacturing Company's *Newsletter* there have been listed names of a number of institutions which are putting out monthly bulletins. Grace Hospital has been publishing a bulletin once each month for the past three years, and it has been interesting to note that since the Lewis letter went out requests for copies of this bulletin have been received from some thirty-odd hospitals throughout the United States — as far west as Spokane and as far south as Texas.

It has been the endeavor in the Grace Hospital bulletin to tell interesting facts about the hospital in very short paragraphs which are easily read, and to have as small a sheet as possible, with pictures. From the comments which have been made by numerous people, it is felt that this bulletin has been the means of creating a much better knowledge of the hospital and its problems in the minds of the public, and it has also secured for the hospital many new friends.

It is not possible for those who are busy each day administering the affairs of our hospitals to tell the stories of our institutions to individuals and to the public generally, but a house organ does offer this opportunity. It must be so short and the reading so interesting that people will look forward to receiving it and can read it in a very few minutes.

* * * *

PUBLICITY

Good newspaper publicity is almost invaluable to the modern hospital. Whether the publicity consists of long stories about certain phases of hospital operation or certain hospital departments, or whether it consists of short articles dealing with various happenings in the institution, it is of interest to the general public and the newspapers are always glad to print it.

Of particular note are the fine publicity which the Norwalk Hospital receives in its papers and also examples of the same thing from the Charlotte Hungerford Hospital in Torrington.

The relationship of hospitals with newspaper management and newspaper reporters should be most cordial because there is a community interest which can only be served only through our news agencies.

* * * *

NORWALK HOSPITAL REPORTS BUSIEST MONTH

Statistics just completed at the Norwalk Hospital indicate that January was the busiest month in its history with a total of 5,315 days care. This is just 250 days more than the previous record of August last.

In January a year ago, 4,655 days care were given, so this year the hospital was about 14% busier. It is significant that the daily average of patients was 171 against a previous high record of 163. When it is remembered that the hospital has properly in place only 193 beds and that during the month 171 were constantly occupied, some idea is secured of how busy the hospital has been and how constant the pressure is for accommodations on the various floors. Actually the adult beds were used to practically 100% of capacity as most of the vacancies occurred in the Children's Ward and at times on the Maternity Floor. The other floor of the hospital usually had nearly every bed filled, with reservations for vacancies as they occurred.

Other comparative figures are as follows:

	1940	1939
Operations	184	175
X-Ray Examinations and Treatments	551	437
Laboratory Examinations	4,362	3,868
Births	81	59

February has continued at the same pace or faster. In fact, February 6 showed the largest census in the history of the hospital, 198 patients in comparison with 193 beds properly in place. Naturally the entire organization is looking forward to the time when it will be possible to enlarge the existing facilities.

(The Norwalk Hospital is to be congratulated on its splendid advancement. Particularly, however, is it to be congratulated on its excellent publicity. With the above story about the busiest month, we received from Mr. Brough, the superintendent of the above hospital, a clipping of an article which appeared in their local paper, entitled "Miracles in Modern Surgery," and in which a reporter had written approximately two columns about an operation which he had witnessed at the Norwalk Hospital. It is a well written article and one which would promptly attract the attention of the news readers. Mr. Brough also sent us another article which appeared in the Norwalk paper, written by a special reporter about the 818 babies born in that institution during 1939. In the course of the story, the writer went into great detail telling of the excellent facilities which were available for the care of the mother and for the care of the new-born baby and managed to get in a piece of very interesting information; namely, that for almost two years, there has not been a maternity death in that hospital. This, truly, is a record of which any institution may be exceedingly proud.—*Editor.*)

* * * *

NEWS FROM THE NEW BRITAIN GENERAL HOSPITAL

During the last few months extensive alterations have been in progress in the X-ray and Clinical Laboratories of the New Britain General Hospital. These changes have been necessary in order to accommodate the increasing load which both of these two divisions have been called upon to handle. New equipment has been purchased and alterations in the physical lay-out of both divisions have been instituted.

In the x-ray department, the new equipment includes a Thermax tube for treatment and diagnosis, a double focus GE tube for diagnosis, two diagnostic tables, a complete gastro-intestinal fluoroscopic, fluorographic and radiographic unit (200 m.a.), a single focus tube for the genito-urinary table, a laminograph and two illuminators. In addition, complete shock-proofing has been installed throughout the department. The x-ray division is now equipped to handle all types of diagnostic and treatment procedures. During the past three months, there has been a marked increase in pelvimetry studies, this increase amounting to more than 400 per cent over the previous three months.

A re-arrangement of table space in the laboratory has reduced crowding and increased the efficiency of the work performed. A considerable amount of new apparatus and equipment has been purchased, and new luminescent lights have been installed. The increase in the amount of work performed by the laboratory has been so marked that an additional technician has been employed.

The hospital supply of 100 mgm. of radium, under lease from the Radium Chemical Company, has been augumented by an additional 150 mgm. from the National Cancer Institute. The tumor clinic now has a sufficient amount of radium for all of its present and future needs.

* * * *

THE CHARLOTTE HUNGERFORD HOSPITAL, TORRINGTON

Doctor Albert W. Buck, Director of the Charlotte Hungerford Hospital, recently returned from Boston after attending the Annual meeting of the New England Hospital Association.

During the past month the daily occupancy of the Charlotte Hungerford Hospital, reached a new high of 138. During the month of February, the average daily census was 114.5, the highest in the history of the hospital.

Recently a new and improved type of resuscitator was presented to the Charlotte Hungerford Hospital by the Ladies Auxiliary.

* * * *

NEW HAVEN HOSPITAL

Due to the increasing number of patients being treated at New Haven hospital, James A. Hamilton, director of the hospital, reports that within the next two or three years a program calling for a $2,000,000 fund to erect three new buildings will have to be executed.

Although the fund-raising program is not considered for the near-future a committee has been appointed to study the situation and it is estimated that 250 more beds will be needed. Also needed by the institution will be the income which will be realized by the formation of a $5,000,000 endowment fund, which will be used to maintain the additional beds, support the dispensary work and building construction.

The buildings needed and which are contemplated are one for the care of private and semi-private patients; one for the treatment of women's diseases, and an isolation building for contagious diseases.

☆☆

FUTURE PROGRESS

(*Continued from Page 186*)

some improvement has taken place in compensation practice since the special Committee of the State Medical Society made its investigation in 1935-1936 the distribution of compensation cases among physicians is not altogether satisfactory. The Chairmen of the respective district committees should discuss this subject with the physicians within their districts who are interested in compensation practice.

We are especially fortunate in having in our midst excellent talent to solve the many problems that confront us. We are also fortunate in having some of the best universities and colleges in the country, the personnel of which we should seek in our efforts to improve the health of the people and the standards of medical practice. County and State Committees should be chosen carefully and wisely to obtain men who are interested in the project before them and who will be willing to serve unselfishly for the benefit of all.

☆☆

A household that has one person ill enough to die from tuberculosis is fertile ground for future cases. Oakes, Marian, Amer. Jour. of Nursing, Dec., 1939.

SECTION ON Proctology

Proctologic Section Meeting.

The Section on Proctology will meet on May 23 at the Hotel Bond, Hartford, at 3:30. The program is announced elsewhere in this issue of the Journal. All members of the Society are urged to attend, as the committee is attempting to make the program of interest to the general practitioner, as well as to the specialist. Anyone particularly interested in proctology is urged to register as a member of the section.

* * * *

Meeting of the American Proctologic Society

The annual meeting of the American Proctologic Society will be held at the Jefferson Hotel, Richmond, Va., on June 9, 10, and 11. Doctor Emmett H. Terrell will be host to the Society, and according to the preliminary notice a very full program has been arranged. Arrangements are being made so that the members may return to New York after the Annual Dinner and Dance on Tuesday night, June 11, arriving in New York in time for the opening session of the Section on Gastro-Enterology and Proctology of the American Medical Association.

* * * *

Proctologic Number Of The Medical World

The March number of the Medical World is devoted almost exclusively to articles on Proctology. The editorial is written by Doctor John L. Jelks of Memphis, a former president of the American Proctologic Society now a Senior Fellow of that society. Other articles are by Doctor Martin S. Kleckner, the president of the American Proctologic Society, and many other well known proctologists. In all there are fifteen original proctologic articles in the Journal. The issue is well worth considerable study by those interested in the subject.

-The- General Practitioner's Forum

Although still in the experimental stage, Sulfamethylthiazol is gaining clinical support. Originally developed and already proved to be efficient in Staphylococcus Aureus infections, reports from conservative sources indicate value in other coccus invasions. Most interesting has been its use in Streptococcus Viridans Bacterial Endocarditis. Given both intravenously and by mouth in sufficient dosage to produce a blood concentration of about 5 mgm., it has produced encouraging results. Present information about the drug is limited to a few facts. It is known to be less toxic than sulfanilamide or sulfapyridine and is better tolerated. However, once started, it must be continued until the end of treatment. Temporary withdrawal and subsequent readministration may cause a toxic reaction. Finally, it seems to have a greater tendency to form renal stones than the other two.

The drug is available to hospitals, free of charge, provided that they are willing to make complete laboratory and clinical reports of cases to the manufacturer.

* * * *

As clinical experience with the sulfanilamide group of drugs increases, certain basic facts are becoming apparent. It is now established that it works with greatest efficiency in those cases having adequate drainage of the focal infection. For example, gonorrhea in the male; a meatotomy and a dressing which allows free exit for the pus increases the percentage of cures with the drug alone. In peritonitis, both general and localized, after drainage is established, sulfanilamide definitely shortens the course of the disease and has reduced the mortality. In pneumonia, doses of potassium iodide alternated with the sulfapyridine thin the bronchial secretions, promote drainage and reduce the incidence of complications.

Locally in open infected wounds, applied either as the dry drug or in water suspension, it acts with suprising speed.

After months of animal experimentation, Nylon, a synthetic substitute for silk is being used as a ligature and suture material in humans. It is a strong non-absorbable and non-absorptive thread in all thicknesses and can be sterilized repeatedly without deterioration or loss of strength. The surgeons using it have applied it in many surgical procedures and are enthusiastic about its possibilities.

* * * *

TeLinde at the 1939 A.M.A. convention recommended the installation of an ounce of 1% solution of mercurochrome into the uninary bladder, immediately following gynecological surgery. Objective result was to reduce the incidence of post-operative catheterizations. Rucker and others applied this procedure in obstetrics following operative delivery. Their experience with it led to a conclusion that it was a simple and worth while addition to the delivery technique.

* * * *

Speaking out of a large experience with gastro-intestinal disturbances, Sullivan, at a recent post-graduate conference in Washington, brought out some pertinent facts about the management of gastric and duodenal ulcers. After reviewing all the newer drugs and treatments, he stressed the fact that they were useful in selected cases only. For the average case he recommended: detection and correction of the emotional factor involved; no smoking or a drastic reduction in the amount; calcium to reduce nerve irritability; tincture belladonna in ascending drop doses to tolerance; mild sedation when needed; small frequent feedings of a low residue high caloric diet; controlled rest habits. In the acute bleeding cases he advocated: total bed rest; morphine in adequate dosage; nothing by mouth for at least 72 hours; intravenous fluids and transfusion if needed.

T. P. R., M.D.

Our Neighbors

MAINE

Doctor and Mrs. George G. Averill of Waterville, Maine, are the donors of $42,000 to the Tufts College Medical School. The fund, to be turned over to the school during the years of 1940 and 1941, will be devoted to the establishment of the Averill Department of Anatomy in memory of Professor Charles P. Thayer. Known as an industrialist, Doctor Averill was one of the first physicians graduated from Tufts nearly half a century ago. The gift will provide the entire top floor of the new medical school building, located in downtown Boston at the New England Medical Center. The new building will be erected as soon as the entire $750,000 needed has been obtained.

* * * *

NEW JERSEY

Important anti-tuberculosis laws were enacted by the Legislature of New Jersey in July, 1939. The new legislation requires that Boards of Education shall periodically determine, or cause to be determined, the presence or absence of tuberculosis in any or all pupils. Physical examinations of teachers and school employees are to be conducted at least once in three years; and diagnostic data obtained by means of laboratory tests, fluoroscopy, or x-ray examinations may be required. The scope of these examinations including frequency, procedure and selection of pupils is to be determined by the State Board of Education.

* * * *

NEW YORK

The Committee on Public Relations and Economics of the Medical Society of the State of New York has been attempting without success to improve the status of medical relief in that state. The State Society's proposition, as presented to the House of Delegates last

The PROFESSIONAL EQUIPMENT Co. X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS. TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

April, included the following points: (1) establishment of professional advisory committees in local welfare districts; (2) revision of fee schedules now in force; (3) reduction in the amount of red tape to the minimum needed for quick and accurate management of medical relief and the payment of fees; and (4) retention without exception by the indigent of the physician or physicians of their own choice. Because the opposition has apparently come from the Social Welfare Department of the State, the committee has thought it advisable to see that each county welfare officer is approached by representatives of the county medical societies in the effort to secure first hand information as to the attitudes of each welfare officer on the recommendation of the Medical Society of the State of New York for reorganization and supervision of medical relief. The committee of the State Society considers the general situation existing at the moment to be intolerable.

Fifteen members of the class of 1890, Bellevue Hospital Medical College, met in New York City on March 9 to celebrate the fiftieth anniversary of their graduation, which was also the fiftieth anniversary of their beginning the practice of medicine. The class originally numbered 144, of whom 35 are living. All are over 70 years and with a few exceptions are still practicing their profession. As invited guests on this occasion were present two physicians who were members of the faculty of the medical school in 1890 as instructors in the Department of Anatomy: Doctor John F. Erdmann and Doctor Henry F. Silver of New York City.

- NEWS -
from County Associations

Fairfield

The Annual Meeting of the Fairfield County Medical Association will be held at the Stratfield Hotel at 4:00 P.M. on April 9. Election of officers and transaction of usual business will be followed by dinner. Mr. Waldeman Kaempfert, Science Editor of the New York Times, will be the guest speaker. Mr. Kaempfert will talk on some phase of the general subject of Socialized Medicine from the viewpoint of a newspaper editor.

At the February meeting of the Stamford Medical Society, Doctor Mortimer N. Hyams of New York City gave an unusually interesting talk on Office Gynecological Problems and on various vaginal operative procedures.

At the March meeting of the Bridgeport Medical Association, Doctor Maxwell Finland talked on the treatment of pneumonia, giving an excellent summary of the indications and contra-indications for both drug and serum therapy, and for the combination of the two.

On Tuesday evening, March 12, the Stamford Medical Society was host to the County group. A large gathering heard Doctor Russell Cecil of New York City speak on the subject "Principles of Serological Treatment In Infections." Doctor Cecil presented his subject in the most lucid and interesting manner. This meeting was another in the series arranged for the year on the general subject of infection, and maintained the high standard of excellence characterizing the whole series.

Doctor William T. Godfrey has been named to the office of Vice-Chairman of the Medical Board of the Stamford Hospital, and Doctor Ralph W. Crane has been elected Secretary of the Staff to fill the place left vacant by the death of the late Doctor John J. Cloonan.

Doctor Wendell J. Washburn has been appointed Director of the recently reorganized Urological Service at the Stamford Hospital, and Doctor Jay E. Starrett has been named assistant.

The Stamford doctors continue merrily with their favorite indoor sport, bowling, every Thursday afternoon. Between twenty and thirty of the profession have been striving to improve their scores. Doctor Stanley H. Osborn of Hartford was a surprise visitor at one of the recent gatherings. The Stamford team has issued a challenge to any medical group in the State to a match on the alleys. Any acceptances?

* * * *

Hartford

The Editor received a telephone call recently from Boston. On the other end of the line was none other than Doctor Harry J. Burkholder of

Alpena, Michigan, an intern at the Hartford Hospital only twenty years ago. He was on a visit to his daughter who is now a student there in the School of Occupational Therapy.

Doctor D. Dillon Reidy has been certified by the American Board of Urology following examinations recently held by the Board in Chicago.

The Surgical Section of the Hartford Medical Society, which had been allowed to linger somewhat, was revivified and a renewal of meetings took place on February 19, when papers concerning various aspects of Cirrhosis of the Liver were read by Doctor Louis P. Hastings, Perry Hough, Samuel Donner and A. W. Branon.

Medical meetings at this time of year seem to come thick and fast. Notable among them are the meetings of the American College of Physicians in Cleveland, The Philadelphia County Medical Institute in Philadelphia the first part of April, our own State and County meetings which are in the immediate offing, and others. No less of importance in value are some of the coming meetings of the Hartford Medical Society. On April 1, Doctor Frank H. Lahey of Boston will favor us with a talk on "The Latest Developments in Surgery." He will also give a Clinic at St. Francis Hospital at 5:00 P.M. on the same date. Following him there will be as guest-speaker of the Hartford Medical Society, Doctor William Murphy of the Peter Brent Bingham Hospital of Boston who is an outstanding authority on "Anemia." He will have some interesting movies of blood conditions which should prove most graphic and valuable. Then on May 6, Doctor Warren Cole, Professor of Surgery of the University of Illinois will speak. It is hoped that we may have Doctor Murphy and Doctor Cole give us Clinics in addition to their talks. Doctor Fuller Albright of Boston, spoke to us recently on "Metabolic Bone Diseases." He proved to be a very entertaining, interesting speaker and both his talk before the Society and his clinic at the Hartford Hospital were well received and quite valuable.

Doctor Thomas C. Carey is convalescing at his home following his recent illness.

Litchfield

The Spring meeting of the Litchfield County Medical Association will be held at the Charlotte Hungerford Hospital on April 23. Luncheon will be served at 1 P.M., following which the business meeting will be held. The guest speaker on this occasion will be Doctor Ernest Daland, Director of the Pondville and Westfield Hospitals in Massachusetts.

Doctor Bernard S. Brody of the Department of Neurological Surgery of the Yale University Medical School gave a very interesting and instructive talk on Cranio-Cerebral Injuries to the members of the Torrington Medical Society on Wednesday evening, March 6, at the Charlotte Hungerford Hospital. Doctor Brody's lecture was illustrated by lantern slides.

At a recent meeting of the Torrington Medical Society the following officers were elected:

Herbert C. Oelschlegel, President
Floyd A. Weed, Vice-President
Michael E. Giobbe, Secretary & Treasurer.

* * * *

Middlesex

Alexander J. Mozzer, M.D., formerly a member of the staff of the Westboro State Hospital, Westboro, Massachusetts, has been added recently to the staff of the Connecticut State Hospital, Middletown. Doctor Mozzer comes from Manchester.

Doctor Gustaf E. Lindskog, assistant professor of Surgery at Yale Medical School, addressed the Central Medical Society at the meeting held in Bengston-Wood Hall, March 11. His subject was "Surgical Treatment of Bronchiectasis."

The Middlesex Hospital in Middletown was recently given a Bell orthopedic table by Mary Hazen Arnold in memory of her sister, the late Lucy A. Hazen of Haddam. The gift was most gratefully received by both the hospital and the medical staff.

* * * *

New Haven

A Blood Donors' League has been organized in the City of New Haven, similar to the one now in operation in Hartford. The details of operation are to be carried on by Station WICC, the three hospitals and the New Haven Medical Association rendering assistance and advice. This League will serve as a valuable aid in cases of emergency where patients are not financially able to supply their own blood donors.

Doctor Clifford Kuh, Chairman of the Committee on Industrial Health, Connecticut State Medical Society, was one of the speakers at the Second Annual Congress on Industrial Health recently held in Chicago. The subject of his paper presented at the Round Table Discussion was "Organized Medicine and Industrial Health."

Alumni Day at the Yale University School of Medicine — as reported in the Yale Alumni Weekly:

During the forenoon and early afternoon of Alumni Day graduates of the School of Medicine and Yale alumni who have graduated from other medical schools visited the laboratories and clinics. At half-past three, visitors, members of the staffs of the School and of the New Haven Hospital, students and guests assembled in the auditorium of the Farnam Memorial Building to hear reports of developments of the past year in the School and Hospital and to listen to accounts of scientific research.

Dean Bayne-Jones expressed gratitude to his colleagues and to many friends for the great assistance given him in the conduct of the School since 1935, and spoke of his deep regret in being unable to accept the honor of reappointment as dean for another term of five years.

Mr. James A. Hamilton, director of the New Haven Hospital, outlined the growth of the Hospital, its enlarging sphere of service to the State of Connecticut, the community of New Haven, the Schools of Medicine and Nursing, and its function for providing trained personnel for many types of professional work in the field of medicine.

Doctor John R. Paul presented an account of the important new studies which he and Doctor James D. Trask have been making on poliomyelitis in recent years.

Doctor Gustaf E. Lindskog described new advances in thoracic surgery, illustrating his address with photographs of results of operations he is performing for the removal of diseased portions of lungs.

At the conclusion of these more formal exercises alumni, Faculty, and students adjourned to the Club Room in Sterling Hall of Medicine for refreshments for an informal meeting with President Seymour.

* * * *

As Walter Lippman might have reported it:

To those in the confidence of the ones behind the scenes who are "in the know", to use the venacular of the diplomatic circles, the meeting on February 22 of the Committee of Twenty purporting to be Graduates of the Yale School of Medicine without any particular or especial portfolio, that is to say simply Sons of Yale coming back to indulge a nostalgic whim, was probably fraught with more significance than might appear to those who do not enjoy such confidences.

It has been the custom for many years for men and women who have been graduated from any one of the several Schools of the University to return on so-called Alumni Day which for considerable number of years has been arranged to coincide with Washington's birthday, or February 22, to return to the Alma Mater in order to get first hand effective knowledge regarding the operation and activities of the University.

To one with a lively memory of many such enlightening occasions in the past two decades or twenty years the situation of this particular year must have seemed to afford a peculiar opportunity for events of more than momentary and purely sentimental significance. The spiritual refreshment that comes to a man or woman in revisiting the world within the world where he or she formulated the aspirations and cultivated the methods and techniques for attaining those aspirations — was, as usual, in evidence on all countenances. In addition to this obvious glow of spiritual refreshment on the faces of all about, still one could discern a darkling, foreboding cast. Could there possibly be any connection between this almost perfectly concealed appearance of anxiety and the fact — which is indeed fact, brazenly acknowledged in all of the worlds capitals — the fact that at this particular time, — Alumni Day was fraught — very, very fraught?

* * * *

As Lucius Beebe might have reported it:

No sooner were the words of benediction

with which Dean Bayne-Jones ended the session of oratory, learning and funds-solicitation, out of his mouth than the corridors and great halls were seething with the pack of thirsty scientists and philosophers driven as one to the bistro. The portals ajar revealed the plush Chesterfieldian salon awash with tosspots and toss potesses plunging for cherries in a hogshead of Vieux Mode, cuvee circa hier. Platoons of white smocked jongleurs fobbing as garcons undulated through the glittering milieu balancing mammoth discs of lacquered alloy laden with firkins of fresh Beluga. Here was the bejeweled wife of a research fellow holding court for a knot of sleek internes — languorously recounting that little affaire d'honneur in Marakesh last summer. In that recess, redolent with Turkish tobacco and L'Aimant — the luscious Mme. — flamboyantly displaying the ruby given her for hush-hush after that little swimming party in the fountain with Rajah Mmjjb, describing great sensuous arcs and sectors with her emerald spangled, carved ebony and ivory, old gold inlaid, beaten silver chased, two and a half foot cigarette holder, related the fascinating experiences in Crimea that led, according to the boulevardiers, to her immolation in the Nursing School. She was suddenly interrupted by an incredible tour en l'air; as the moments passed and still the spinning, whirling form gathered velocity as the core of a simoon— the hum of persiflage, badinage and whispered assignations gave way to slack jawed amazement. Who is this fellow, anyway? Presently the retour began but not until the very end of it could the mulled mob discern the identity of the dervish. Nijinsky Winternitz— ha, who but he would dare! Amid cascades of applause and vintage, the Senior Chorale Club joined with the Madrigal Moppets in a stentorian and frankly sour rendition of "As the Blackbirds in the Spring" while the entire company executed a complicated rigadoon — meanwhile unanimously electing the sommelier at Scheherazade the new dean of the School.

* * * *

Windham

The genial secretary of the Windham County Medical Association, Doctor Ralph L. Gilman, has recently been elected a Fellow of the American College of Physicians.

Letters to the Editor

February 21, 1940

To the Editor:

Will you be kind enough to publish the following in the next publication of your State Medical Journal (or Bulletin) for the Finnish Relief Fund, Inc? It will be greatly appreciated if you will do this.

The Finnish Relief Fund, Inc. is sponsored by Mr. Herbert Hoover. It is approved by the Finnish Minister in Washington, D.C., His Excellency Hjalmar Procope.

It has the main purpose of accepting for the Finnish people and transmitting to Finland any funds contributed for this great cause by the American people.

Contributions, unless specifically intended to be used for war material, will be used for food and clothing for the Finnish civilian population, many of whom are suddenly made homeless by having their houses irreparably demolished by the incendiary bombs from Russian aeroplanes.

Members of the American Medical Association are the only doctors who will be asked to contribute through this Fund.

It is hoped the profession will respond as generously as possible. It is further hoped that every doctor will make some contribution, and no matter how small it may be, it will be gratefully accepted. We believe the profession should have one hundred per cent of its members become contributors to this most worthy cause.

No money is deducted for expenses from any contribution made through this Fund, and every dollar donated arrives in Finland worth one hundred cents.

No salaries are paid and no financial remunerations are made to officers on duty with the Finnish Relief Fund. Expert auditors make a daily checkup of the donations acquired and chart the results.

The National Chairman of the Medical Division of the Professional Groups of the Finnish Relief Fund, Inc. is Dr. John Frederick Erdmann of New York.

A director (chairman) for the Medical Division has been or will be appointed from each state who will try to get in touch with every member of the American Medical Association of that state by such method as he deems best.

The Executive Director of the Medical Division is Dr. Kerwin W. Kinard who has offices at Fund Headquarters.

All checks should be made payable to the Finnish Relief Fund, Inc. and sent to the Medical Division of the Finnish Relief Fund, Inc., 420 Lexington Avenue, New York, N.Y.

Thanking you for your cooperation and kindness, I am

Cordially yours,
Kerwin W. Kinard
Director, Medical Division
Finnish Relief Fund, Inc.

The Doctor's Office

Doctor David Walter Byrne announces the opening of an office for the practice of Urology at 179 Allyn Street, Hartford.

☆☆

CONNECTICUT TUBERCULOSIS ASSOCIATION

The Connecticut Tuberculosis Association has recently been formed with the following officers elected: David R. Lyman, M.D., Wallingford, president; Charles C. Wilson, M.D., Hartford, vice president; Mrs. W. W. Wilcox, Jr., Middletown, secretary; John T. Walsh, Ansonia, treasurer. The executive committee will consist of the officers and Mayor John W. Murphy, New Haven; Joseph I. Linde, M.D., New Haven; Mrs. Hadlai Hull, New London; Mrs. William Grippin, Bridgeport; and Professor Ira V. Hitchcock, New Haven. The new association will become incorporated, will take over the direction of the Christmas seal campaign for this State, and will also undertake that phase of the local tuberculosis work which is being relinquished by the State Tuberculosis Commission as state agent for the National Tuberculosis Association.

☆☆

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

New Haven Hospital

Thursday, May 2, 4:00 p.m.
Surgical Auditorium
Room 1039 — Farnam Memorial Building

PROGRAM

PROBLEMS AND ERRORS IN DIAGNOSIS OF MALIGNANT TUMORS

Tumors of Central Nervous System — Max Taffel, M.D.
Tumors of Lung — Gustaf E. Lindskog, M.D.
Tumors of Kidney — Clyde L. Deming, M.D.
Tumors of Uterus — Arthur H. Morse, M.D.
Tumors of Gastro-Intestinal Tract — A. W. Outerson, M.D.
The Connecticut State Tumor Program — Herbert F. Hirsche

These meetings are open to all practicing physicians. After each paper there will be opportunity for questions and discussion from the floor.

Refreshments will be served following the meeting. Those intending to remain are requested to notify the chairman, Doctor C. L. Larkin, 101 North Main Street, Waterbury, in order that proper provision may be made.

☆☆

THE NEW ENGLAND JOURNAL OF MEDICINE

The 1940 budget of the Massachusetts Medical Society carries an appropriation of $20,500 for the expenses of the New England Journal of Medicine. This is exclusive of a small salary paid to the Editor Emeritus of the Journal.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

SPECIAL NOTICES

FIFTH ANNUAL POSTGRADUATE INSTITUTE OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY

The Fifth Annual Postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, Philadelphia, April 15-20. The program devoted to Cardiology, Vascular and Nephritic Diseases should prove a very interesting and instructive one. Registration is five dollars and should be addressed to the Philadelphia County Medical Society, 21st and Spruce Streets, Philadelphia, Pa.

* * * *

EIGHTH AMERICAN SCIENTIFIC CONGRESS

The Eighth American Scientific Congress will be convened at Washington, D.C., May 10-18 for two cardinal purposes: to advance scientific thought and achievement; to assist in celebrating the fiftieth anniversary of the founding of the Pan American Union. The Congress is divided into eleven sections, one of which pertains to public health and medicine. This section is presided over by Doctor Thomas Parran and will concern itself with nutrition, tuberculosis, cancer, chemotherapy (recent advances), diseases of the heart, rehabilitation of physically handicapped children, and tropical and other diseases. The tentative program looks very attractive, including as it does trips to Mount Vernon, Luray Caverns, Williamsburg and the New York World's Fair. Registration will be at Congress Headquarters at the Pan American Union and should be completed prior to the opening of the Congress.

ATTENTION, GOLFERS!

The American Medical Golfing Association's Twenty-Sixth Annual Tournament will be held at Winged Foot Golf Club, Mamaroneck, New York, Monday, June 10, 1940. Winged Foot has two famous championship courses and a beautiful club-house.

Some 250, out of the 1,360 Fellows of the A.M.G.A., are expected to take part at Winged Foot in the 36-hole competition. Each contestant will play both courses. The hours for teeing off are from 7:00 a.m. to 2:00 p.m.

The sixty prizes, in the nine events, will be distributed after the banquet at the club-house at 7:00 p.m.

Officers of the A.M.G.A. for 1940 are George Washington Hall, M.D., Chicago, President; D. H. Houston, M.D., Seattle, First Vice-President; Grayson Carroll, M.D., St. Louis, Second Vice-Presidnt; Bill Burns, Secretary, 2020 Olds Tower, Lansing, Michigan.

The New York Golf Committee is composed of James Craig Joyner, M.D., Chairman, 718 Park Avenue, New York; Edwin G. Zabriskie, M.D., Charlton Wallace, M.D., Orrin Page Wightman, M.D., and Asa Liggett Lincoln, M.D.

All members of the A.M.A. are eligible for Fellowship in the A.M.G.A. For registration application write the Secretary.

PRELIMINARY PROGRAM

NEW ENGLAND HEALTH INSTITUTE

Hartford, Connecticut, April 15-19, 1940

SECTION AND CHAIRMEN

No.	*Section*	*Chairmen*
I.	Public Health Administration	John A. Ferrell, M.D.
II.	Preventable Diseases	Wilson G. Smillie, M.D.
III.	Sanitary Engineering	Roscoe H. Suttie, C..E
IV.	Vital Statistics	Halbert L. Dunn, M.D.
V.	Laboratory	Elliott S. Robinson, M.D.
VI.	Venereal Disease	R. A. Vonderlehr, M.D.
VII.	Industrial Hygiene	R. R. Sayers, M.D.
VIII.	Cancer	C. L. Larkin, M.D.
IX.	Tuberculosis	David R. Lyman, M.D.
X.	Child Hygiene	Martha M. Eliot, M.D.
XI.	Crippled Children	R. C. Hood, M.D.
XII.	Nutrition	George R. Cowgill, Ph.D.
XIII.	Public Health Nursing	Mary D. Forbes, R.N.
XIV.	Mental Hygiene	Eugene Kahn, M.D.
XV.	Health Education	Clair E. Turner, Dr. P.H.
XVI.	Milk, Food and Drugs	E. G. Woodward, A.M.

SCHEDULE OF LECTURES

Monday, April 15

			Section
2:00 P.M.	Odors and Tastes in Water	J. A. Newlands	III
	Efficiency of Tests for Syphilis	J. F. Mahoney	V
	Improving Facilities for Obstetrical Care	A. N. Creadick	X
3:00 P.M.	Protection of Public Watersheds	E. S. Chase	III
	Bringing Health Services Closer to the People Concerned	W. G. Smillie	I
	Quantitative and Screen Tests for Syphilis in Public Health Laboratories	A. B. Wadsworth	V-VI
	The Role of the Public Health Nurse in a Program of Maternal Health	M.D. McCorkle	X-XIII
4:00 P.M.	Cross Connections and Backflow as Related to Drinking Water	A. P. Miller	III
	Coordinating Community Effort for Health	A. G. Horning	I-XV
	Laboratory Diagnosis of Gonorrhea and the Problems of the Gonococcus Carrier	C. J. VanSlyke	V-VI
	Defects and Deviations of Early Child Development	A. Gesell	X-XIV

Tuesday, April 16-(See Note)

			Section
9:30 A.M.	Evaluation of Local Health Work	I. V. Hiscock	I-XV
	Gonorrhea as a Major Public Health Problem	N. A. Nelson	VI
	Health as Influenced by Posture	J. C. Kuhns	XI-X
	The Automobile as a Killer	H. Barsantee	II-IV
10:30 A.M.	Ragweed as a Health Hazard	A. E. Wilkinson	II
	Legal Problems of Health Officers	J. A. Marr	I
	Syphilis in Industry	P. Padget	VI-VII
	A Balanced Program for Crippled Children	R. C. Hood	XI
11:30 A.M.	Training for Modern Public Health	H. S. Mustard	I
	The National Program for Venereal Disease Control	R. A. Vonderlehr	VI
	Cerebral Palsy	W. M. Phelps	XI
	*Newer Aspects in Industrial Medicine	Clifford Kuh	VII*
2:00 P.M.	Experiences in Localizing Health Services	M. W. Barnard	I
	Syphilis in Pregnancy and the Offspring	W. P. Boardman	VI-X
	Rheumatic Heart Disease	J. R. Paul	XI
	Functions of the Association of Connecticut Tumor Clinics	C. L. Larkin	VIII
3:00 P.M.	Basis of Effective Service by Health Officers	J. A. Ferrell	I
	The Present Status of the Dental Health Problem	F. C. Cady	X
	The Premarital Blood Test Law and Accomplishments		
	(a) In Rhode Island	L. A. Round	
	(b) In New Hampshire	T. P. Burroughs	
	(c) In Connecticut	S. H. Osborn	VI-V
	The Social Component in Heart Disease	E. Cohen	XI
4:00 P.M.	The Dental Situation	P. R. Howe	X-XII
	Local Health Service in New England	J. O. Wails	I
	Evaluating the Effectiveness of the Public Health Nursing Service in the Prevention of Syphilis and Gonorrhea	E. H. Morris	VI-XIII
	Trends in School Health Education	C. E. Turner	XV
7:00 P.M.	Banquet — Housing and Health	C. E. A. Winslow	

Note: All day meeting of New England Sewage Works Association at Middletown, Conn.

Wednesday, April 17

			Section
9:30 A.M.	The Public Health Aspects of Industrial Hygiene and the Part of Local Health Department in the Problem	R. R. Sayers	VII-I
	Dysentery and Diarrheal Diseases	A. V. Hardy	V-II
	Financing and Budgeting a State's Business	O. G. Saxon	I
	Sanitation of Swimming Pools and Bathing Places	J. H. L. Giles	III
10:30 A.M.	Essentials of Budgeting	W. N. Kirkham	I
	What Industry is doing in the Prevention of Occupational Diseases	C. D. Selby	VII
	The Laboratory Diagnosis of Fungus Infections		V
	Sanitation of Summer Camps and Tourist Places	M. A. Pond	III
11:30 A.M.	What the Insurance Fraternity is Doing in the Control of Occupational Diseases	W. S. Paine J. B. Lamenzo R. C. Stratton	VII

---

* Program of the Connecticut State Medical Society

			Section
	The Laboratory Diagnosis of Virus and Rickettsial Diseases		V
	Population Estimates Between Censuses	J. H. Watkins	IV
	What the Health Officer Can Do in the Housing Field	W. J. Scott	III
2:00 P.M.	Relation of Analysis and Inspection of Water Supplies	C. D. Howard	III-V
	Industrial Hygiene Training for Public Health Workers	P. Drinker	VII
	The Confidential Death Certificate and Some Results	T. J. Duffield	IV
	*Maternal Mortality in Connecticut	J. H. Howard	X*
3:00 P.M.	Sewage Disposal in Unsewered Areas	C. L. Pool	III
	The Effect of Various Dusts on the Human Organism	L. U. Gardener	VII
	County Vital Statistics	M. T. Bellows	IV
	*The Family Physician and Public Health	J. H. Root	X*
4:00 P.M.	Inspection of Public Eating Places	J. M. Curry	III
	Industrial Solvents: Their Physiological Effects	H. F. Smyth	VII
	The Census of 1940	H. L. Dunn	IV
	*The State Medical Society and Public Health	C. Barker	I*

An Evening Program on Health Education is being planned.

Thursday, April 18

			Section
9:30 A.M.	Malnutrition — A Challenge in Public Health	F. G. Boudreau	XII
	A State Tuberculosis Program	J. I. Linde	IX
	Industrial Dermatitis—Incidence, Cause and Prevention	L. Schwartz	VII
	Evaluating the Effectiveness of a Public Health Nursing Service—Determining the Needs of the Community	R. Houlton	XIII
10:30 A.M.	Nutrition — (subject to be announced)		XII
	Institutional Side of the Tuberculosis Problem	H. B. Campbell	IX
	The Use of Respiratory Protective Equipment in the Protection of the Worker's Health	W. P. Yant	VII
	Evaluating the Effectiveness of a Public Health Nursing Service — Its Administration	E. G. Fox	XIII
11:30 A.M.	Nutrition in the Public Health Program	M. M. Heseltine	XII
	Tuberculosis Case Finding	P. S. Phelps	IX
	Lay Responsibility for the Present and Future of Public Health Nursing	G. Cross	XIII
	Engineering Methods of Occupational Disease Control	B. Postman	VII
2:00 P.M.	What City Families Spend for Food	F. M. Williams	XII
	Essentials of a Pneumonia Program	E. S. Rogers	II
	The Integration of Mental Health and Public Health Programs	C. E. A. Winslow	XIV
3:00 P.M.	Keeping up with the Vitamins	G. R. Cogwill	XII
	Scarlet Fever of Today	E. N. Place	II
	Ways of Developing and Utilizing Psychiatry in Community Health and Social Welfare Programs	G. S. Stevenson	XIV
	Evaluating the Effectiveness of an Industrial Nursing Service		XIII
4:00 P.M.	The Treatment of Syphilis	A. B. Cannon	VI
	Communicable Diseases in Schools	C. C. Wilson	II-XV
	Emotional Disorders as a Health Problem	A. H. Ruggles	XIV
	Evaluating the Effectiveness of a School Nursing Service	M. E. Chayer	XIII

Friday, April 19

			Section
9:30 A.M.	Public Health Aspects of the Cancer Problem	L. C. Kress	VIII
	The Medical Economics of Mental Health	W. A. Bryan	XIV
	Cooperation Between Agencies in the Sanitary Control of Milk	I. V. Hiscock	XVI
	Principles of Teaching		XIII
10:30 A.M.	Research Problems in Cancer	S. Bayne-Jones	VIII
	Potentalities for Mental Health of School Health Services	F. J. O'Brien	XIV
	Safety of the Milk Supply	T. W. Workman	XVI
	Applying Principles of Teaching in Public Health Nursing	F. Benjamin	XIII

---

*Program of the Connecticut State Medical Society

			Section
11:30 A.M.	Delay in the Diagnosis of Cancer	E. J. Ottenheimer	VIII
	Mental Hygiene as a Part of Prenatal and Postnatal Child Care	L. J. Thompson	XIV-X
	Informative Labelling for Common Drugs	E. M. Bailey	XVI
	Evaluating the Educational Service of a Public Health Nursing Agency		XIII
2:00 P.M.	Quackery and Charlatanism as a Menace to Venereal Disease Control	W. Clark	VI
	Epidemiology in Cancer	H. L. Lombard	VIII-II
	A Program for the Care of Premature Infants	F. L. McKay	X
	Improving the Diet Through the Use of Milk	E. Batchelder	XVI-XII
3:00 P.M.	Narcotics as a Public Health Problem	L. Kolb	II
	Medical Aspects of Premature Infants	S. H. Clifford	X
	The Problem of Adequate Distribution of Milk to all Income Groups in a City	B. G. Horning	XVI
	The Venereal Disease Program in New Jersey	A. J. Casselman	VI
4:00 P.M.	Maternity as a Family Affair	H. V. Corbin	X-XIII
	Syphilis and Gonorrhea Control (Principles of Case Finding and Case Holding)	C. C. Pierce	VI
	The New Federal Food and Drug Act	W. S. Frisbie	XI

☆☆☆

SCHONLEIN-HENOCH'S PURPURA

(*Continued on Page 207*)

18. Sutherland, G. A., Intussusception and Henoch's Purpura. Brit. J. Child. Dis. 1:23, 1904.

19. Fraser, I., Purpura Simulating the Acute Abdomen. Lancet. 2:525, 1930.

20. Burrows, H., A. Case of Henoch's Purpura in Which a Laparotomy Was Performed. Brit. J. Child. Dis. 1:28, 1904.

21. Silvestre, J. and Gravano, L. Toxicosis Capilar Hemorrhagica Sindromes Renal, intestinal y cutaneo-articular asociados Rev. Asso. Med. Argent. 52:514, 1938

22. Althausen, T. L. and Kerr, W. J., False "Acute Abdomen", Henoch's Purpura and Abdominal Allergy. Ann. Surg. 106:242, 1937.

23. Schatzki, Richard, The Roentgenological Appearance of Intussuscepted Tumors of the Colon With or Without Barium Examination. Am. Jour. Roent. 41:549 1939.

24. Ginsberg, L., X-Ray Diagnosis of Acute Intestinal Obstruction Without the Use of Contrast Media. Ann. Surg. 96:368, 1932.

25. Singer, H. A., The Diagnosis of Perforated Peptic Ulcer. II Differential Diagnosis. Int. Clinics 45th Series. 3:116, 1935.

26. Vaughan, W. T., Food Allergens III. The Leucopenic Index. Preliminary Report. Jour. Allergy. 5:601, 1934.

27. Trimble, I. R., Erythematous Group of Skin Diseases With Especial Reference to Abdominal Pain. J. A. M. A. 96:2010, 1931.

28. Rosenthal, N., The Blood Picture in Purpura. J. Lab. and Clin. Med. 13:303, 1928.

29. Dalldorf, G., A Sensitive Test for Subclinical Scurvy in Man. Amer. J. Dis. Child. 46:794, 1933.

30. Peck. S. M. and Rosenthal, N., Effect of Mocasin Snake Venon (Ancistrodon Piscivorus) in Hemorrhagic Conditions. J. A. M. A. 104:1066, 1935.

31. Piney, A. L., A Case of the Schonlein-Henoch Syndrome. Lancet. 2:1144, 1933.

32. Cotti, L. and Rettanni, G., Considerazioni a proposito di un caso di M. di Schonlein guarito in seguito a malattia da siero. Gior. di Clin. Med. 17:767, 1936

33. Saxon, L., Studies in Autohemotherapy. Report of a Case of Purpura Rheumatics With New Method of Treatment. Ill. Med. Jour. 74:191, 1938.

34. Engelkes, H., Treatment of Hemorrhagic Disorders with Vitamin C. Lancet. 2:1285, 1935.

35. Ainsworth, M. L., Purpuras. Ohio State M. J. 33:849, 1937.

36. Jersild, T., Therapeutic Effect of Vitamin P. Lancet. 1:1445, 1938.

37. Gray, T.. Henoch's Purpura Causing Acute Obstruction Twice in Eight Days. Lancet. 1:841, 1936.

38. Silberman, Henoch's Festschrift. 237, 1890.

☆☆

SMASH HITS

Many of the most dramatic smash hits of 1939 were not viewed on the stage or screen but on the highway, according to the tenth annual safety booklet just issued by The Travelers Insurance Company. The booklet, entitled "Smash Hits," records pictorially and graphically the facts about accidents in which 32,100 persons were killed and almost a million and a quarter others were injured last year.

• OBITUARIES •

GEORGE SHATTUCK WHITESIDE, M.D.
1873-1940

Doctor George Shattuck Whiteside died January 29, 1940, in New York City, of cerebral hemorrhage. He was born in Boston in March 1873, and was the son of Alexander Whiteside and Eleanor Shattuck Whiteside. He graduated from the Harvard Medical School in 1897. After serving as surgical interne at the Massachusetts General Hospital he practised surgery for six years in Boston, during which time he was assistant in anatomy at the Harvard Medical School, assistant genito-urinary surgeon at the Boston Dispensary, and secretary of the Harvard Medical Alumni Association.

In 1904 he removed to Portland, Oregon, where he specialized in urology and practised for many years. In 1917, he entered the service of the United States Navy, and remained there for four years, attaining the rank of Lieutenant Commander. During his stay in Portland he achieved distinction as a urological surgeon, and was assistant professor of genito-urinary surgery at the University of Oregon Medical School. He took a prominent part in medical affairs, and was secretary of the Portland City and County Medical Society for seven years, and for one year its president. He was a member of numerous medical societies, and vice-president of the American Urological Association.

In 1922 he left Portland and came east. The following year he came to New Haven as surgeon to the Winchester Repeating Arms Company, and remained there until 1925 when he took up work with the Travelers Insurance Company at Pittsburgh and New York. In 1930 he retired from practice and was appointed associate surgeon to the Greenpoint Hospital, Brooklyn, a position which he held till his death.

Since leaving Connecticut in 1925, Doctor Whiteside had kept up his associations in the state, spending much of each year in Branford and continuing his membership in the Connecticut State Society. He was an assiduous attendant at the medical meetings and many of our members will have pleasant memories of his witty sayings and cheerful comradeship.

Modest to a degree, he endeared himself to many, and he will be greatly missed. His fortitude and philosophy during a long and trying illness were worthy of admiration.

He leaves a widow, the former Adeline Haven Cheever, two sons, Frederick Shattuck Whiteside and George Alexander Whiteside, and one daughter, Mrs. Roger Hale Newton.

Wilder Tileston, M.D.

* * * *

BARTHOLOMEW C. PASUTH, M. D.
1891-1939

Bartholomew Charles Pasuth was born in Bridgeport, Connecticut, on April 15, 1891. He attended the public schools in Bridgeport, graduating from high school in 1910. Following pre-medical work at Yale, he entered the College of Physicians and Surgeons and the University of Maryland in Baltimore from which he graduated in 1916. He served one year of internship in Bridgeport Hospital. He was on the Emergency Hospital staff until May 1918 when he entered the U. S. Army as a Lieutenant in the Medical Corps, serving until the Armistice in November 1918, when he was discharged and resumed his practice in Bridgeport.

He was assistant in medicine at Bridgeport Hospital for several years, resigning last year due to the pressure of work at the Bridgeport Brass Company where he was Plant Surgeon for six years. Doctor Pasuth died after a very short illness on October 6, 1939, from coronary heart disease.

While of a retiring nature, Doctor Pasuth was to those who knew him well a man of exemplary habits and honorable and fair to his fellow physicians. He was a conscientious and hard worker, which may have contributed to his untimely death while apparently in the best of health.

John G. O'Connell, M.D.

• Quarto Notes •

THE BIOLOGY OF ARTERIOSCLEROSIS

by

M. C. Winternitz, M.D.
R. M. Thomas, M.D.
P. M. LeCompte, M.D.
The Department of Pathology
Yale University School of Medicine
New Haven, Conn.

142 pages $4.00
Springfield, Ill. Charles C. Thomas 1938

Doctor Winternitz and his associates have presented in this colorfully illustrated monograph interesting observations on the development and repair of arteriosclerosis. The methods of clearing the pathological material are not new but the presentation is distinctly new in that liberal use has been made of the recent developments in color photography, so that it is possible for the reader to have at hand a very accurate and realistic reproduction of the actual material. The data presented illustrate clearly how arteriosclerotic changes are apt to begin around the mouths of small vessels as they leave the larger artery. Examples and illustrations of early thrombosis in the coronary arteries are presented to show how this process may start as a result of intra-mural hemorrhage from one of the vasa-vasorum. The recanalization of the occluded vessel is convincingly depicted so that it is possible to see how the small capillaries responsible for the new blood channels have their origin from the vasa-vasorum. The monograph lays stress upon the importance of the vasa-vasorum and shows how they can be responsible for arterial destruction and also how they take part in the repair process of recanalization. The book is a clear presentation giving new thoughts as a result of original work with an old method.

R. S. Lampson

* * * *

PHYSICAL DIAGNOSIS

by

Richard Cabot, M.D., and F. Dennette Adams, M.D.

846 pages 391 illustrations 12th edition $5.00
Baltimore, Maryland William Wood & Co. 1938

This is the twelfth edition of this standard textbook, the eleventh having appeared in 1934. One might at first wonder why a new edition was indicated, but after reading through this splendid volume two important features became evident: the addition of new methods (as the symballophone for lateralizing heart murmurs) and the appearance of a new arrangement which emphasizes the relations of physical signs to symptomatology and the clinical picture. An abundance of well chosen pictures, X-ray plates, and electrocardiograms aptly supplement the text and add to the usefulness and readability of the book.

Instead of representing solely the experience of a single author, as did earlier editions, this twelfth edition presents the views of the co-author as well as those of the teaching staff of the Massachusetts General Hospital, thus producing a more complete volume on physical diagnosis that will be not only instructive but interesting to the medical student.

A few very minor criticisms could be raised — in outlining the steps taken in recording a complete history, no mention is made of manifestations of allergy in either the Family History or the Past History; in discussing auscultation of the lungs, the adventitious sounds heard in asthma, bronchitis or bronchial stenosis are called "dry rales" while no mention is made of the frequently used "rhonchi."

W. F. Smith

* * * *

DISEASES OF THE FOOT

by

Emil D. W. Hauser, M.S., M.D.
Assistant Professor of Bone and Joint Surgery, Northwestern University Medical School

472 pages 263 illustrations $6.00
Philadelphia W. B. Saunders Co. 1939

The fact that Doctor Sumner L. Koch has written a special foreword for this book would seem to be particular recommendation for the substance contained therein. Doctor Hauser has apparently had a wide experience in practice in Chicago with an earlier very satisfactory background of training at the Mayo Clinic and abroad.

The text is short, to the point and very readable, the type large and the illustrations excellent. The early chapters thoroughly discuss the anatomy, physiology, and mechanics of the foot followed by a discussion of symptoms and treatment. These are chapters of interest to the general practitioner and surgeon, as well as the orthopaedist on such subjects as circulatory diseases, nerve diseases, skin diseases, and infections. In other words, fractures, dislocations, tumors, disturbances of growth, all subjects related in any way to the feet are adequately and concisely covered. There is a very satisfactory index, making the book readily available as a reference work.

Of particular interest to the orthopaedic surgeon is the detailed description of Doctor Hauser's own technique for correcting a hallux valgus deformity, a procedure which is logical and has yielded good results.

M. Pike

* * * *

ATLAS OF SURGICAL OPERATIONS

by

Elliott C. Cutler, Moseley Professor of Surgery, Harvard University
and
Robert Zollinger, Assistant Professor of Surgery, Harvard University

181 pages Illustrated by Mildred B. Codding $8.00
New York The MacMillan Co. 1939

The authors offer this atlas as an answer to "the countless questions of internes, resident surgeons, students, and assistants over a period of twenty years of teaching as to where they might learn about the intimate technical steps of surgical operations." Chapters on Surgical Technique, Anesthesia, and Preoperative and Postoperative Care precede the illustrations and should be helpful to the surgeon, although the chapter on Anesthesia is not as up to date as one might expect. Each plate of illustrations is faced by a page pertaining to the details and technic of the particular operation under consideration.

Surgery of various parts of the body is covered, — tonsil, thyroid, breast, chest, abdominal wall, gastro-intestinal, and extremities. In addition there are thirty four pages devoted to gynecological procedures but urological, brain and orthopedic procedures are not included, only as a few of the latter appear in the section on Extremities. The illustrations, made by the medical artist of the Peter Bent Brigham Hospital in Boston, are clear and concise.

This atlas should be of greatest value to medical students, hospital interns and residents, as a guide to an understanding of the details in the more common procedures of general surgery.

* * * *

THE NEUROGENIC BLADDER

by

Frederick C. McClellan, M.S., M.D.

Instructor of Surgery, University of Michigan Medical School

206 pages $4.00
Springfield, Ill. Charles C. Thomas 1939

This very readable handbook presents concisely facts concerning neurogenic bladder. The literature recently has had a number of articles on neurogenic bladder, mainly because a new diagnostic procedure has been introduced, ie, the cystometer. The abundance of information contained in the various articles has left the reader in a confused state of mind which Doctor McClellan's book dispels.

The book is nicely planned, beginning with the normal bladder, neuro-anatomy and neuro-physiology, and proceding to abnormal neurological bladder dysfunctions.

Toward the back of the book Doctor McClellan has summarized the cystometric findings in 100 neurogenic bladders and following this has included 49 cystometric charts demonstrating normal, infantile, adult bladders, and then the various abnormal bladders, atonic and hypertonic, myogenic and neurogenic, etc. These charts and graphs are excellently indexed and readily found.

Doctor McClellan's book is a compact summary of the neurogenic bladder — a subject which has been verging on the chaotic.

C. Mirabile

* * * *

FRACTURES AND OTHER BONE AND JOINT INJURIES

by

R. Watson Jones

723 pages 1200 illustrations 50 shillings
Edinburgh, Scotland E. & S. Livingstone 1939

A large volume, condensing the clinical and radiographic records with conclusions of 12 years' work in the treatment of 47,300 bone and joint injuries, constitute this latest contribution to orthopedic surgery emanating from England. The photography is exquisite and the bookmaking more beautiful than any such text coming from the bookmakers of recent years. It is printed entirely upon fine, glossy paper with over 1200 illustrations. As most texts are wont to do this particular volume devotes considerable space to the histological features of repair of fractures. As Mr. Jones states, "The training of the fracture surgeon must begin with his physiological and pathological reactions of living tissues, only after which does the art of surgery develop with the aid of mechanical apparatus and manipulative technique." This is proven by the author's own works which are most comprehensive and enlightening.

An occasional full colored illustration is quite pleasing to the eye of the reader. An interesting addition consists of X-ray tracing on cellophane sheet placed over the actual reproduced roentgenograph. In this way the plates are made more easily understandable. A question and answer device is used occasionally by covering the post-reduction X-ray reproduction with a hinged flap, somewhat holding the reader in suspense until this extra flap is lifted. Every fracture is enumerated and Mr. Jones' form of treatment detailed with illustrations. The literature has not been combed extensively but sufficiently to give quite a satisfactory bibliography.

In the appendix Mr. Jones delineates the organization of a fracture service in a general hospital. His fracture service follows closely that set up by the British Medical Association Fracture Committee. According to Mr. Jones, special fracture services in a general hospital have overcome the former indifferent treatment and lack of organization responsible for increasing the average incapacity period following fractures. His essentials of a fracture service are:

1. Segregation of cases.
2. Massage, gymnastic and X-ray section devoted to fracture treatment.
3. Daily open fracture clinic at which all fractures received during any 24-hour period are reviewed by the attending the next morning at the daily fracture clinic.
4. Unity of control, illustrated by a weekly and a monthly to yearly follow-up clinic which will provide invaluable information in the general improvement of treatment.

The reviewer has visited Mr. Jones' clinic and can attest to its excellency and proficiency. Someone will criticize him for presuming to write such an ambitious text with only 12 years' experience, but Mr. Watson Jones has crowded into these brief 12 years an experience commensurate with the largest and most exacting clinic. Boehler's Clinic in Vienna seems small compared with that presided over by R. Watson Jones.

C. W. Goff

THE 1939 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY

Edited by

Joseph B. DeLee, A.M. M.D.,
Professor of Obstetrics, University of Chicago
Medical School
and
J. P. Greenhill, B.S., M.D., F.A.C.S.
Professor of Obstetrics and Gynecology
Loyola University Medical School

736 pages 123 illustrations $2.50

Chicago, Ill. The Year Book Publishers 1940

Like its predecessors for many years this volume presents in a concise and readable form the latest data in the fields of obstetrics and gynecology. Each year this particular summary is invaluable as a reference volume to both the student and the practitioner and its value is enhanced the more by the personal contributions of the two editors. The 1939 Year Book is the largest of its title ever published. In many instances controversial data is offered, with comments either by the author's quoted or by the editors, enabling the reader to make his own deductions.

In the half devoted to obstetrics may be found discussions of the part which prenatal nutrition plays in fetal tooth development, of the development of fetal electrocardiography, of the calculation of the end of pregnancy, and of the treatment of varicose veins during pregnancy. Heart disease, tuberculosis, diabetes and pneumonia are discussed in relation to pregnancy, and the relation of toxemia to chronic vascular and renal disease and the most recent concepts of pre-eclampsia and recurrent pregnancy toxemia are presented. The effect of anesthesia on the newborn, uterine inertia, induction of labor, disproportion in border line pelves, the Cesarian problem, maternal mortality — all these and many more are reviewed in the light of our latest concepts.

The half of the volume dealing with gynecology is no less comprehensive. Here we find a resume of recent work on sterility, menstruation and its disorders, the use of sex sterols, the female sex hormones and in particular stilbestrol. Getting abdominal post operative patients out of bed early is supported. The use of sulfanilamide is reviewed. Pelvic heat applied in inflated rubber bags is described, the use of presacral neurectomy in primary dysmenorrhea, and irradiation of the pituitary and ovaries in functional menstrual disorders and in sterility. The larger problems of ovulation and of endometriosis are discussed and the use of the Wertheim operation for cancer of any part of the uterus is supported. In the chapter on operative technic are found many excellent cuts.

To peruse this volume is always to find something hitherto overlooked, so full is it of information. It is well indexed and it represents a total of 632 articles chosen from 66 United States and 44 foreign journals.

Indicated for Memorable Moments

It's professional to let your taste prescribe the Scotch of its own choosing...fine-flavoured Johnnie Walker. For there's no finer whisky than Scotch and Johnnie Walker is Scotch at its smooth, mellow best.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820...
Still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE

Wyeth

HAS SHOWN A CONVINCING RECORD* OF EFFECTIVENESS IN ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae • Trichomonas vaginalis Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

SEXUAL PATHOLOGY

A STUDY OF DERANGEMENTS OF THE SEXUAL INSTINCT

by

Magnus Hirschfeld, M.D.

363 pages Revised Edition $3.00
New York Emerson Books, Inc. 1940

This book was originally published in three volumes. The present issue is an excellent translation by Jerome Gibbs and its subtitle, A Study of Derangements of the Sexual Instinct describes the nature of the contents.

This work is very interesting and covers a wide range in the field of sexual abnormality. There are three main divisions, Sexual Symbolism, Hypereroticism and Impotence. The author not only discusses sexual-pathological phenomena but correlates these with scientific references. There are various interpretations concerned with physiologic disturbances which should enhance the appeal of a book of this nature. As in most works of this type, there is very little given over to treatment.

This volume is again an attempt to bring the pathological in sexual life to general appreciation. It is based on living experiences and "did not originate at a desk in the editorial room, but in the consulting room." It is highly recommended to the profession.

L. H. Gold

TEN YEARS IN THE CONGO

by

W. E. Davis

301 pages $2.50
New York Reynal & Hitchcock, Inc. 1940

To ride a bicycle over jungle trails for days on end, to do major surgery on a two inch board laid across two saw horses at times in semi darkness and under the most trying circumstances, to hunt elephants through mud and water shoulder deep — all these experiences were part of the everyday program of the author of this book, a medical missionary in the Belgian Congo. The story is fascinating in places and affords a very good description of the native Congolese, his customs, diseases and odors.

The publishers tell us this is a new kind of book. Rather it is a return to the nineteenth century type written by the medical missionary, but an improvement over the old style in phraseology and humanization. Few physicians would care to exchange even the lazy, peaceful trip down one of the Congo rivers in a mission boat, as described by this author, for his own exacting practice with its many complex problems. Yet commerce is opening up the Belgian Congo, leaders are needed and the opportunities for the ambitious are manifold.

This volume is just off the press and affords interesting reading.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1939-1940) 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) 5

ORIGINAL PAPERS:

What Is Renal Clearance? . . . Robert W. Clarke, Ph.D., New Haven, Conn. 256

Virus Pneumonia . . . . Stanhope Bayne-Jones, M.D., New Haven, Conn. 258

SYMPOSIUM OF MEDICAL PROGRESS:

Renal Hypertension . . . . . Louis H. Nahum, M.D., New Haven, Conn. 259

Collateral Circulation to the Heart . . Louis H. Nahum, M.D., New Haven, Conn. 259

Sensitive Carotid Sinus . . . . . Louis H. Nahum, M.D., New Haven, Conn. 260

Diagnosis and Treatment of Patients with Low Metabolism — Edwin F. Gildea, M.D., New Haven, Conn. 261

Vitamin K in Bleeding Diseases. . . Martin Heinemann, M.D., New Haven, Conn. 262

Specific versus Mixed Therapy in Vitamin B Deficiency — Martin Heinemann, M.D., New Haven, Conn. 263

In What Cases should one Employ Protamine Insulin? — Paul Lavities, M.D., New Haven, Conn. 264

Cortico-Sterone, Its Clinical Uses . . Paul Lavities, M.D., New Haven, Conn. 265

Is There an Iodine-Fast State? . Paul Lavities, M.D., New Haven, Conn. 266

Renal Stones . . . . . . Clarence Robbins, M.D., New Haven, Conn. 266

Prophylactic Removal of Rectal Polyps . Simon B. Kleiner, M.D., New Haven, Conn. 269

Premonitory Symptoms of Acute Coronary Thrombosis — Edward Gipstein, M.D., New London, Conn. 270

ABSTRACTED PAPER:

Etiology of Cancer in Man in Light of Animal Experimentation — William Cramer, M.D., London, England 254

PROGRAM — 148th ANNUAL MEETING, CONNECTICUT STATE MEDICAL SOCIETY 245

TECHNICAL EXHIBIT 252

EDITORIALS:

Hartford Once Again 273

More Light on Cancer 274

Problem of Low Back and Sciatic Pain 274

Premarital Examination 276

National Physicians Committee 276

Hugh Cabot, Salesman 277

FROM THE SECRETARY'S OFFICE 278

CONNECTICUT HOSPITAL ASSOCIATION 281

ANNUAL REPORTS OF CONNECTICUT STATE MEDICAL SOCIETY (1939-1940) . 285

GENERAL PRACTITIONER'S FORUM 284

NEWS FROM COUNTY ASSOCIATIONS 301

SPECIAL NOTICES 304

OBITUARIES:

Ernest Herman Smith, M.D. . . . D. Chester Brown, M.D. 306

QUARTO NOTES (Book Reviews) 306

THE DIABETIC'S DOLLAR

Now Goes 28 Times Further

● Since April 1, the diabetic can buy as much Iletin (Insulin, Lilly) for 3.5 cents as he purchased in 1923 for $1.00. Thirteen reductions in the price of Iletin (Insulin, Lilly) have resulted from large-scale production and improvement in marketing facilities.

ELI LILLY AND COMPANY

Principal Offices and Laboratories, Indianapolis, Indiana, U. S. A.

MAIN STREET, HARTFORD,

IN 1857

(Looking South from Pearl Street)

WEDNESDAY, MAY 22

9:00 REGISTRATION — Main Lobby

9:30 SCIENTIFIC SESSION, Ballroom — Joseph I. Linde, Presiding.

Panel of visiting discussants:

Paul D. White, Boston	James C. White, Boston
William S. McCann, Rochester, N.Y.	Foster S. Kellogg, Boston

Increasing Incidence of Degenerative Diseases.	Walls W. Bunnell, Farmington
Symptoms Compelling Attention to the Heart	Louis H. Nahum, New Haven
How to Evaluate the Limitations of a Patient with Cardiac Disease.	John A. Wentworth, Hartford
Fallacies and Deficiencies in Treatment of Cardiac Patients	William J. Bruckner, New Haven

Ten minute recess

Mental Manifestations in Cardio-Reno-Vascular Disease.	Edwin F. Gildea, New Haven
Post-infectious Nephritis in Childhood	Daniel C. Darrow, New Haven
Indications for Therapeutic Use of Intravenous Amino-acids.	Lee E. Farr, New York

11:30 DISCUSSION BY MEMBERS OF THE PANEL.

Choice of Anesthesia in the Presence of Peripheral Vascular Disease.

Management of Pregnancy Associated with Cardiac Disease.

The Use of Graduated Exercise in Cardiac Disease.

Accepted Classification of the Toxemias of Pregnancy.

Question Period

1:30 SECTION LUNCHEONS. Members and guests may lunch with any section or at tables reserved in the main dining room.

2:30 SECTION MEETINGS — open to all.

ANESTHESIA — Old English Room, Ralph M. Tovell, presiding.

Choice of Anesthesia.	Meyer Saklad, Providence
Survey of the Anesthesia Service at Grasslands Hospital, 1938 to 1940.	Harold F. Bishop, Valhalla, N.Y.
Anesthesia in Relation to Cardiac Disease.	L. Corsan Reid, New York
The Injection of Procaine and Alcohol in the Diagnosis and Treatment of Intractable Visceral Pain.	James C. White, Boston

White, Paul D.

Boston. M.D. Harvard University, 1911. Lecturer in Medicine, Harvard Medical School; Physician in charge of Cardiac Clinic and Laboratory, Massachusetts General Hospital; Vice-President, American Heart Association.

McCann, William S.

Rochester, N.Y., M.D. Cornell University, 1915. Dewey Professor of Medicine, Rochester University; Physician-in-Chief, Rochester Municipal Hospital and Strong Memorial Hospital.

White, James C.

Boston. M.D. Harvard University, 1923. Assistant Professor and Tutor in Surgery, Harvard Medical School; Assistant Visiting Surgeon, Massachusetts General Hospital; Consulting Surgeon, Massachusetts Eye and Ear Infirmary.

Kellogg, Foster S.

Boston. M.D. Harvard University, 1910. Assistant Professor of Obstetrics, Harvard Medical School; Assistant Obstetrician, Boston Lying-in Hospital; Member of the American Board of Obstetrics and Gynecology.

WEDNESDAY, MAY 22 — Section Meetings (Cont.)

DERMATOLOGY AND SYPHILOLOGY — Egyptian Room, Michael J. Morrisey, Presiding.

William S. McCann will be the guest of this Section.

Problems in the Treatment of Early Syphilis.	Allan K. Poole, New Haven

INDUSTRIAL MEDICINE — Room 7, Clifford Kuh, Chairman. Organization Meeting.

ORTHOPEDICS — Ballroom, J. Leonard Vickers, presiding.

Modern Treatment of Low Back Pain and Sciatica.	Philip D. Wilson, New York

HEZEKIAH BEARDSLEY PEDIATRIC CLUB — Moorish Room, Oliver L. Stringfield, presiding.

Paul D. White will be the guest of this Section

The Preventive Aspects of Heart Disease in Children	Katharine G. Dodge, New York
Congenital Urological Anomalies.	Chris. H. Neuswanger, Waterbury

WOMEN'S MEDICAL SOCIETY — Room 6, Edith A. MacLeod, presiding.

Foster S. Kellogg will be the guest of the Society

THE CONNECTICUT HOSPITAL ASSOCIATION — Modernistic Room, Wilmar M. Allen, presiding.

Hospital Public Relations. (Speaker to be announced)

Round Table Discussions.

MEDICAL RECORD LIBRARIANS

9:00 Registration. Business Meeting, Harriet Lyman, presiding.

2:00 Round Table Conference, Grace Gillespie, presiding.

1. Reasons for being a member of the national and local association and for being registered. 2. Tumor clinic and tumor clinical records. Explanation of classification used in tumor clinics throughout the State. 3. Demonstration of punch card system for recording diagnosis and operations. 4. The growing demand for information for hospital plans and what to do about it. 5. Recordat, method of photographing histories to conserve time and space. 6. History taking and form filling in relation to insurance.7.Status of the ordinary medical record as a legal document. 8.Demonstrations of Soundex, Kardec, and housing for such records. 9. Nomenclature problems.

7:30 ANNUAL DINNER: THE CONNECTICUT STATE MEDICAL SOCIETY — Ballroom.

Speaker: Haven Emerson, New York. "What Our People Really Need For Health."

THURSDAY, MAY 23

9:00 **REGISTRATION** — Main Lobby

9:30 **SCIENTIFIC SESSION** — Ballroom — A. Nowell Creadick, Chairman Program Committee presiding.

Panel of visiting discussants:

T. Grier Miller, Philadelphia
George P. Muller, Philadelphia
Louis E. Phaneuf, Boston
Albert D. Ruedemann, Cleveland.

Manifestations of Nervous and Mental Disease — Referable to the Gastro-intestinal Tract.	Benjamin V. White, Hartford
Character Physique and the Gastro-intestinal Tract.	George A. Gosselin, Hartford
Neurologic Lesions that give Gastric Symptoms.	James C. Fox, Jr., New Haven
Eye and Ear Lesions with Gastric Symptoms.	Shirley H. Baron, New London
Tumors of the Gastro-intestinal Tract.	Ashley W. Oughterson, New Haven

Ten minute recess

Diagnosis by Gastroscopy	Samuel D. Kushlan, New Haven
The Necessity for Rectal-Sigmoidal Examinations in Routine Physical Examinations.	Simon B. Kleiner, New Haven
Ruptured Ovarian Follicles Simulating Appendicitis.	Floyd A. Weed, Torrington
The Significance of Pelvic Pain in Gynecological Conditions.	Arthur H. Morse, New Haven

11:30 **DISCUSSION BY MEMBERS OF THE PANEL.**

Question Period

1:30 **PRESIDENT'S LUNCHEON**—Ballroom

Presentation of Incoming President — Arthur B. Landry.

Address of Retiring President — Joseph I. Linde.

THURSDAY, MAY 23 — SECTION MEETINGS

3:30 SECTION MEETINGS — open to all.

EYE, EAR, NOSE AND THROAT — Egyptian Room, Shirley H. Baron, presiding.

End Results of Eye Muscle Surgery	Albert D. Ruedemann, Cleveland
Difficulties in Interpretation of Nasal Accessory Roentgenograms.	Frederick M. Law, New York
An Analysis of Fundus Changes in Sinus Thrombosis.	Isidore Friesner, New York

NEUROLOGY AND PSYCHIATRY — Moorish Room, Chester Waterman, presiding.

Progress in Hormone Therapy of the Psychoses.	Marjorie B. Patterson, Hartford

OBSTETRICS AND GYNECOLOGY — Ballroom, Emerson L. Stone, presiding.

Manchester Operation in the Treatment of Uterine Prolapse.	Louis E. Phaneuf, Boston

PHYSIOTHERAPY — Modernistic Room, Harry E. Stewart, presiding.

Treatment of Subacromial Bursitis.	Alexander L. Bassin, New Haven

PROCTOLOGY — Room 7, Simon B. Kleiner, presiding.

George P. Muller will be the guest of this Section.

The Role of Radiation Therapy in Treatment of Rectal Cancer	George E. Binkley, New York

RADIOLOGY — Old English Room, Samuel M. Atkins, presiding.

T. Grier Miller will be the guest of this Section.

The Roentgenological Examination in Hemorrhage from the Upper Gastro-intestinal Tract.	Richard Schatzki, Boston

CONNECTICUT OCCUPATIONAL THERAPY SOCIETY — Room 8, Harry Kromer, presiding.

Community Program	Benjamin G. Horning, Hartford
An Exhibit of Occupational Therapy in Connecticut.	

CONNECTICUT BRANCH, AMERICAN MEDICAL SOCIAL WORKERS—Room 6, Ellen Ogren, presiding.

A Presentation of a Medical-social Case History Showing the Relationship of Medicine and Medical Social Service.

7:00 SECTION DINNERS.

Miller, Grier T.
Philadelphia. M.D. University of Pennsylvania, 1911. Professor of Clinical Medicine, University of Pennsylvania; Chief of the Gastro-intestinal Clinic, University of Pennsylvania Hospital; Research Consultant to the Philadelphia General Hospital.

Muller, George P.
Philadelphia. M.D. University of Pennsylvania, 1899. Professor of Surgery, Jefferson Medical College; Surgeon, Lankenau Hospital; President, American College of Surgeons.

Phaneuf, Louis E.
Boston. M.D. Tufts College, 1913. Professor Gynecology, Tufts College; Gynecologist and Obstetrician-in-Chief, Carney Hospital; Surgeon, Department of Gynecology, New England Medical Center.

CAT.

Ruedemann, Albert D.
Cleveland. M.D. University of Michigan, 1921. Ophthalmologist-in-Chief, Cleveland Clinic; Consulting Ophthalmologist, Women's Hospital.

CAT.

TECHNICAL EXHIBIT

Ballroom

John H. Bumstead, M.D., Director

Booth No. 1

Petrolagar Laboratories, Inc.

Petrolagar Laboratories is offering in addition to samples of the five types of Petrolagar, an interesting selection of descriptive literature and anatomical charts.

Representative
Mr. M. W. AKIN

Booth No. 2

Kemp's Sun-Rayed Tomato Juice, Seggerman-Nixon Corporation Eastern Representative

The pure, natural juice of a specially cultivated strain of tomatoes produced in one locality in Indiana. Selected by U. S. Government grade, carefully cored and trimmed before being converted into juice. All the red-ripe solids of the whole tomato are utilized by Kemp's patented process No. 1746657, which homogenizes the tomato solids by viscolization and makes this juice non-separating, and never thin or watery.

Representatives:
MR. FRED NIXON
MR. JAMES H. MORTON

Booth No. 3

Eisele and Company

Featuring Connecticut Seal Glass Case Self-Sterilizing Clinical Thermometers with Red Reading Mercury, together with the new locking device for Luer Syringes which will lock any needle with a rear head. Also showing Green Plungered Hypodermic Syringes, Hypodermic Needles, Rust-free Suture Needles, Sanelastic Bandages, Surgeons' Blades and Handles, and other specialties.

Representative
MR. LOGAN EISELE

Booth No. 4

Scientific Sugars Company

Cartose, the liquid dextrin-maltose-dextrose carbohydrate for milk modification in infant feeding, Kinney's Yeast Extract and Kinney's Yeast Extraxt Tablets will be displayed.

Representative:
MR. L. J. McDERMOTT

Booth No. 5

Smith, Kline and French Laboratories

Up to date information about Benzedrine Inhaler, Benzedrine Sulfate, Benzedrine Solution, Pentnucleotide, Feosol Tablets and Elixir, Oxoate B, Eskay's Neuro Phosphates and Paredrine Hydrobromide With Boric Acid Ophthalmic.

Representative: not yet assigned

Booth No. 6

R. B. Davis Sales Company

Year by year Cocomalt has kept abreast of growing nutritional knowledge. As the necessity of Vitamin D for routine administration was demonstrated Cocomalt added adequate Vitamin D. When rather widespread deficiency of Vitamin A was shown, this vitamin was increased in Cocomalt. Now Vitamin B1 has been added to Cocomalt — 75 units per ounce. Cocomalt will be displayed and served at the convention.

Representative:
MR. GEORGE DOWDING

Booth Nos. 7-16

The D. G. Stoughton Company

Supplies of interest to physicians and hospitals. Allison wood furniture, metal furniture, Castle sterilizers and lights, Mooradian Short wave, McKesson anesthesia and oxygen therapy apparatus, B.L.B. and nasal catheter outfits, McKesson Metabolor, blood pressure apparatus, diagnostic sets, surgical instruments and rubber sundries, complete line of dressings, drugs and biologicals.

Representatives:
MR. F. O. POUCHOT
MR. H. S. OTTY
MR. OTTO BRENNER
MR. THOMAS PARSEY
MR. RALPH BARNES

Booth No. 8

Jones Metabolism Equipment Company

Demonstrating the original waterless metabolism apparatus the exclusive features of which include a double slope tracing which eliminates the possibility of technical errors; a simplified and accurate slide rule for calculations, and the life time guarantee of accuracy greater than 99%. Twenty years of experience has made possible the production of a foolproof, simple and accurate machine.

Representative:
MR. A. RODMAN

Booth No. 9

The Doho Chemical Company

Auralgan, a modern scientific preparation, containing no phenol, used in the conservative treatment of otitis media.

Representative
MR. H. R. STEINMANN

Booth No. 10

Horlick's Malted Milk Corporation

Nourishing, digestible, appetizing — these are the three outstanding qualities for which Horlick's is famous, whether in powder or tablet form. Visit our exhibit. You will be interested in the many uses from infant feeding to old age — note especially the convenience of the tablets in ulcer diets.

Representative:
MR. T. O. KURTZNER

Booth Nos. 11-12

Professional Equipment Company

Latest developments in medical, surgical and x-ray equipment and supplies.

Representatives:
MR. A. W. TAYLOR
MR. L. B. TERRY
MR. R. E. MANN
MR C. F. HEWITT
MR. D. E. GREIST

Booth No. 13

Surgeons' and Physicians' Supply Company

Physicians' and surgeons' supplies in general. Cysstoscopes and other diagnostic instruments and short wave apparatus. Factory representative from American Cystoscope Makers will be present.

Representative:
MR. GEORGE BROWN

Booth No. 14

Arlington Chemical Company

Proteins and pollens for diagnosis and treatment of allergic conditions, and their new product — Aminoids. Aminoids represents a combination of amino acids and has proved of marked therapeutic value in malnutrition, loss of appetite and weight.

Representative:
MR. B. E. DARY

Booth No. 15

Nestle's Milk Products, Inc.

Featuring Lactogen which for more than fifteen years has given successful results in infant feeding.

Representative:
MR. R. G. NEWLAND

Booth No. 17

E. F. Mahady Company

Featuring surgical sutures sterilized in our own laboratory, laboratory stains and reagents, Burdick physical therapy apparatus, Cutter's prepared intravenous solutions and the newest surgical specialities.

Booth No. 18

Mead Johnson and Company

Servamus Fidem — Mead Johnson will exhibit several new products and will show various examples of their slogan, Servamus Fidem. We are keeping the faith.

Representative not yet assigned

Booth No. 19

C. B. Fleet Company

Phospho-soda (Fleet) a buffer saline laxative known to the medical profession for over fifty years. This eliminant is suggested where a rapid non-griping action is desired. It is recommended in gall bladder disorders. Our duodenal lavage technique (without tube) has been successfully used in gall bladder disturbances.

Representative:
MR. E. R. KELDERHOUSE

Booth No. 20

Davies, Rose and Company

Members of The Connecticut State Medical Society are so well acquainted with the products of the laboratory of Davies, Rose and Company, Ltd., that no further explanation of their merits is necessary.

Representative:
MR. W. B. POOLE

Booth No. 21

E. L. Washburn and Company

We will display new pieces of equipment and new instruments of great interest to the medical profession, particularly the new waterless metabolor manufactured by the McKesson Appliance Company.

Representatives:
MR. F. A. SULLIVAN
MR. C. M. POWELL
MR. J. J. REYNOLDS

Booth No. 22

Lederle Laboratories, Inc.

Featuring hay fever, poison ivy and allergenic products together with globulin modified Lederle antitoxins and selected pharmaceutical products featuring Vi Delta Emulsion and Vitamin B. Complex in both liquid and capsule form.

Representative: not yet assigned

Balcony

J. B. Lippincott Company

Featuring Kugelmass', "Newer Nutrition in Pediatric Practice" and Becker and Obermayer's, "Modern Dermatology and Syphilology;" Dickson and Diveley's "Functional Disorders of the Foot" which has gone into a second printing within five months of publication; Thorek's, "Modern Surgical Technic;" Rigler's, "Outline of Roentgen Diagnosis" and Barborka's, "Treatment by Diet."

The Etiology of Cancer in Man in the Light of Animal Experimentation*

WILLIAM CRAMER M.D.,
London, England

The rapid progress in animal experimentation on cancer has caused a radical change in our point of view of the etiology of cancer in man. By reason of this progress cancer prevention now appears theoretically possible. It was formerly thought that the change in cells which we know as cancer occurred suddenly, but from experimentation and research it has been found to be a very slow process. Autonomous growth, without relation to the structure of the organ in question, constituted the former concept of cancer, but that too has been proven incorrect.

Period of Carcinogenesis.

In respect to the time which is required for cancer to develop it is known that in the mouse, whose life cycle is 1½ years, 5 to 6 months or ¼ of the life cycle is required for the development of experimental cancer. In rabbits, whose life cycle is 5 years, approximately the same period, ¼ of the life cycle or 1¼ years is required. The same is true of dogs. In man this period of carcinogenesis requires from 10 to 50 years and explains in part the high age incidence of cancer in man late in life. *One half the total mortality in human cancer occurs in persons* 65 *years of age and over.*

Factors in Development of Cancer

There are two main factors in the development of cancer, viz., (1) the host factor which depends on the relative susceptibility of the patient, and (2) the carcinogenic factor.

Host tissue undergoes changes, either hyperplasia such as skin growths (warts and epitheliomata), or hypoplasia as atrophy of the stomach mucosa. Either of these changes acts as the site for cancer development. In hyperplasia the increase is evident; in hypoplasia excitation of overgrowth is called forth from the cell.

If X = carcinogenic agent
and Y = host factor
then in each case X multiplied by Y = C (a constant) or carcinoma.

This formula has been demonstrated in mice. Either X or Y may vary. Thus, if X is constant, occurrence of cancer in mice is totally dependent on the susceptibility of the host so that in one strain of mice it is almost impossible to produce cancer, whereas in another strain it is easy. Applied to man the same formula produces the same result. Thus, not all heavy smokers who have the carcinogenic factor develop cancer of the tongue.

The nature of the carcinogenic agent is not definitely known. It may be a somatic change in the cell or a physiochemical change. However, we need not know its actual consistency in order to proceed against it.

There are certain preparatory causes of cancer. For cancer of the skin, the tongue, the lungs, and the digestive tract we have the alcoholic professions, i.e., brewers, barmen, etc. For cancer of the breast and the uterus we have the hormones, the follicular hormone of the ovary, for example.

The agent is specific for the tissue, i.e., we have one agent for cancer of the uterus and another agent for cancer of the breast. There is also the hormonal balance in the body which if upset, will result in cancer. This is best illustrated by the following formula:

Endocrine Balance

Development of Mamma	*Involution*
1. Synergist Adrenal cortex	1. Anterior pituitary hormone
2. Carcinogen Follicular ovarian hormone.	2. Adrenal medulla

Any increase in synergistic activity or any decrease in antagonist activity will result in cancer.

---

*Abstract of paper presented before the 15th Clinical Congress, Connecticut State Medical Society, September 19-21, 1939.

Heredity

This is a tissue heredity, i.e., a family will have cancer of the breast in several generations but that family will not inherit cancer of the stomach or uterus. A family history of uterine cancer is important for there is a strong familial inheritance. Cancer in males is relatively non hereditary. The external group of cancers (skin, stomach, lungs, and tongue) are relatively non hereditary. However, the external group incidence is greatly influenced by social status. Thus, by dividing the English people into five groups, those in the highest group were found to have the lowest incidence and those in the lowest group the highest incidence of "external cancer."

Precancerous Conditions

The incidence of "external cancer" should be diminished by education of the lower strata of society.

Vincent - Plummer's disease (hypochromic anemia in women associated with dysphagia) has been found to be a precursor of cancer of the oesophagus. Treatment of the syndrome with iron will prevent the malignancy.

The precancerous lesion of cancer of the stomach is as yet unknown.

Mammary disease and mammary cancer have been found to be a precursor of cervical cancer. Therefore, treatment of this condition should be immediate and adequate.

Many more precancerous lesions are being discovered daily.

Importance of History

It is important to go backward into the history of the cancer patient for many years (50 years for instance) and to search for the very first evidence of any abnormality in every case. Herein lies the future for the discovery of the precursors of cancer. The war in Europe has brought to an end cancer research in England, America must carry it on.

THE AMERICAN SOCIAL HYGIENE ASSOCIATION IN 1939

Recent figures obtained by the American Social Hygiene Association show that one in twenty people, taking the population as a whole, is infected with syphilis. The venereal diseases still far outnumber all other serious infectious diseases. The incidence of syphilis is 50 per cent greater than that of tuberculosis. Syphilis cases are 13 times more numerous than diphtheria. Syphilis still attacks 28 times as many as infantile paralysis.

Nine more states were added to 10 already requiring premarital examinations of both men and women applicants for marriage licenses, to reduce syphilis among new families. Fourteen more states were added to 3 requiring physicians to secure blood tests of expectant mothers at time of first examination, as a step in checking congenital syphilis. The Association encouraged the passage of these laws and gave its legal and technical experience to legislators and other groups interested in new laws or the improvement of existing faulty legislation.

Congress appropriated $5,000,000 under the second year of the Venereal Disease Control Act of 1938, friends of the Association who knew the importance of continuing this work rallying to its support when there was danger of its being impaired.

At home and in the field the Association's legal staff aided and counselled numerous state and local groups regarding social hygiene legislation and completed a 400-page summary of venereal disease control legislation in the 48 states.

Further, the legal staff studied medical quackery in 44 cities in 25 states—the Association realizing that the progress of the anti-syphilis campaign was being seriously impeded by all sorts of medical quacks, charlatans, herbalists and nostrum dispensers.

The PROFESSIONAL EQUIPMENT Co. EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

What Is Renal Clearance?*

ROBERT W. CLARKE, PH.D.,
New Haven, Conn.**

The idea of renal clearance grew out of the experimental approach to renal physiology in which the role of the blood as the sole source of income to the kidney is emphasized. Since urine is made from blood by the kidney, it was thought that the excreted quantities of various urinary solutes might be related to the rates at which those solutes are supplied to the excretory organ. To apply this concept one must have exact, quantitative measurements rather than mere qualitive observations of the factors involved. Let me take urea as an example because it has been thoroughly studied by this method.

The concentration of urea in the urine reflects only the relationship between two fairly distinct renal processes, namely, water excretion and urea excretion. If one investigates the quantity of urea excreted, one learns only the general level of protein metabolism, complicated by the possibility of a changing storage of urea. If the concentration of urea in the blood is noted, one sees the equilibrium between urea production and urea excretion. If, however, one considers the quantity of urea actually excreted and makes allowance for the amount available for excretion by dividing the excreted quantity by the plasma urea concentration, a factor is obtained which is a direct quantitative measure of how the kidney is excreting this particular substance. This factor has been named the urea clearance.

The word clearance is used because one can regard the quantity, calculated as I have indicated, as the volume of blood which the kidney would have completely cleared of urea while it was producing urine, i.e., excreting urea, at the observed rate. It is always calculated in cubic centimeters per minute; and a report such as "Urea clearance, 80cc per minute" means that eighty cubic centimeters of that subject's blood just suffice to furnish the urea excreted in one minute. To put it another way, the urea excreted in one minute could have been obtained by the kidney by completely clearing eighty cubic centimeters of blood of that substance. Urea, as is well known, is a highly permeating or diffusible substance. It is not surprising to find that its excretion is linked to that of water. A urea clearance of about 75 cubic centimeters a minute is regarded as the average of normal cases, if there is an ample water excretion going on at the same time. If for any reason the water excretion is low, a further correction factor must be used in order to compare a suspected case with known normals.

The renal clearance of each constituent of urine can be calculated in exactly the same way: by dividing the rate of excretion of any substance (in milligrams per minute) by its simultaneous concentration in the plasma (in milligrams per cubic centimeter.) The study of clearances of various substances at the same time is giving valuable evidence about the distinct functions of the glomerulus, where pure filtration takes place, and the tubule, where the reabsorptive and secretory functions of the kidney are carried out. The starch-like polysaccharide inulin has been used experimentally because the renal tubules are wholly impervious to it, while it is freely filterable at the glomerular tuft. Those properties of inulin permit us to say that the inulin clearance is identical with the rate of glomerular filtration. Studies of clearances of phenol red and other dyes have shown that they are excreted largely by active secretory processes in the tubular cells. Simple calculations from these data indicate in quantitative terms the reabsorptive activity of the cells of the tubules.

The clearance of any substance, no matter by what mechanism the kidney excretes it, must of course be smaller than the concurrent flow of

---

*Read at the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.
**Instructor, Physiology, Yale University School of Medicine, New Haven.

blood through the kidneys. For a few compounds in experimental use, such as some of the rapidly excreted dyes and x-ray contrast media, the clearance approaches the blood flow, or in other words, the extraction ratio approaches 100%. There is no known blood constituent which is entirely removed from the blood by one passage through the excretory organ; some, and usually most, still remains in the renal venous blood. This fact justifies the use of blood concentration of any solute rather than blood flow as the factor representing the supply available for excretion in the formula stated above.

The urea clearance is the only clearance which is in wide clinical use. The data are usually expressed as a comparison with the average value for healthy individuals and a statement of the relation as a percentage deviation above or below the assumed normal or standard.

A renal clearance, in summary, is a quantitative measurement of the efficacy with which the kidney is acting to clear the blood of a stated constituent. Clearance measurements put stress on purely renal factors in conditions where excretion is abnormal and renal pathology exists. From such measurements of the clearances of particular substances, among which urea and creatinine probably lead in practical importance, the site, nature and extent of disordered kidney function may be deduced.

☆☆

HOSPITAL TRAINING AS SUPPLEMENT TO MEDICAL SCHOOL

Sooner or later our whole concept of hospital training must be revised. We must decide whether we are training doctors for general practice or for specialization. The facts and theories of medicine and its related sciences should be taught in medical schools. *The art and science of the general practice of medicine, not neglecting its economic and social aspects, should be taught in hospitals and taught during a space of two or three years.* The product of this period of training should be a doctor well versed in the practical application of his theoretical and factual knowledge, who should be able to practice general medicine with confidence and with average ability. The argument that medicine has become too complicated for any one person to encompass its whole field is sound only when one thinks in terms of specialized knowledge; in terms of general practice it loses force if only because the general practitioner must and does have a fund of knowledge surpassing that of the specialist and as a rule practices medicine of a very acceptable quality.

How is this revision in the method and character of hospital training to be accomplished? There may be several or more solutions, but to be effective all must be based on the criterion that *hospital training should be arranged solely for the benefit of the interne.* The niceties of hospital routine must not enjoy perpetual immunity from change. To be further effective, hospital training must simulate private practice as much as is possible. Therefore, rotation of services should consume not more than one-half of the training period and during the remainder the interne should have under his care all types of cases in the order of their hospital admission — just as he must care for all types of conditions when he enters private practice. Under supervision, the responsibility for the diagnosis and treatment of each case should be his, and in this manner he will obtain a survey of the field of general medicine. Obviously this change from service rotation to general care of all cases will disrupt present routine and will require thoughtful intelligent planning — but it can be done. As with all change, this too will meet with opposition from those who do not understand its purpose or do not realize that present-day hospital interne training is educationally obsolete and strangely bereft of accomplishment.

Let us ask ourselves, "What is the purpose of an internship?" If an internship is a teaching and learning process, if it comprises a transition and conditioning period after medical school, then where can the art and science of the practice of medicine be taught, if not in hospitals?

Westchester Med. Bull.,
March 1940

☆☆

Deaths from tuberculosis can be reduced 50 per cent by health supervision of industrial workers in occupations predisposed to the disease, by detection of incipient cases, and by provision of adequate medical and institutional care in the early stages of the disease. Handbook Coop. Health Assn., Utah W.PA., 1939.

Virus Pneumonia*

STANHOPE BAYNE-JONES, M.D.,
New Haven, Conn.

It is now well known that pneumonia in human beings may be caused by certain filtrable viruses. The chief of these are the viruses of influenza, measles and psittacosis. Lower animals also have virus infections of the respiratory tract with inflammation of the lungs and pneumonia. These natural infections in white mice have added difficulties and complexities to the study of similar infections in man. Recently the question has arisen as to whether viruses, other than those mentioned, cause pneumonia in human beings. Is there a specific type of "virus pneumonia"?

During the past two years a peculiar form of pneumonia has been seen in cities in this country and abroad. In 1938 and 1939, Dr. Hobart Reimann observed groups of cases in Philadelphia. Similar cases have been reported from New York, Boston, Chicago, St. Louis, Minneapolis, Georgia, Oregon and England. Dr. Francis G. Blake has informed me that he has seen several cases at the New Haven Hospital which might have been so-called "virus pneumonia," if such a condition exists.

The onset may be sudden or gradual, and the illness at first may be thought to be a severe cold or influenza. Occasionally after a brief period of remission the temperature may rise to 104°F and thereafter, during a week or ten days, may fluctuate between 102° and 104°. After this period the temperature gradually returns to normal in the second or third week. Among the symptoms the most prominent are hoarseness, dyspnea, cyanosis, high fever, and relative bradycardia. The white blood count is normal or slightly increased. There have been a few fatal cases. The disease has been called diffuse bronchiolitis, tracheobronchopneumonia, or bronchopneumonia. It is distinct from lobar pneumonia and pneumococci are not usually found in the sputum. In a few cases the clinical condition resembled typhoid fever, miliary tuberculosis, tularemia or psittacosis. To some observers the infection is a new disease. This appears to be unwarranted. If it is proved to be an entity it will probably be regarded, according to Reimann, as "a newly recognized severe form of an otherwise mild and perhaps commonly encountered infection of the respiratory tract."

The technic of isolation, differentiation and identification of the viruses of diseases of the respiratory tract is extremely difficult and costly. It requires passages through ferrets or mice, cultures in media containing living cells, and intricate immunological tests of the neutralizing powers of various serums. The natural virus infections in the animals used in the tests add hazards and uncertainties to the experimental work. Several years of intensive investigation will be required before conclusive results are obtained. It is not likely that such work will become a routine procedure of diagnostic laboratories. In the meantime physicians will continue to see cases of atypical pneumonia. These should be studied as thoroughly as possible, to make sure that the basis of supposing that a specific virus causes the disease is not laid on the failure to discover the usual bacterial incitants or on the difficulties of clinical differential diagnosis.

At present the question of etiology is unsettled. The virus obtained from two of Reimann's patients was lost before it was completely identified. Investigators whom I have consulted are very cautious in their comments, withholding opinions until more cases have been thoroughly studied. While the possibility exists and while there have been indications that there is a specific type of "virus pneumonia," it must be said today that the case is not proved.

REFERENCES

For general review see: Reimann, H. Arch. Int. Med., 1939, **64**, 381.

---

*Presented at the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

Symposium on Medical Progress*

RENAL HYPERTENSION

Louis H. Nahum, M.D.,
New Haven, Conn.

An important chapter in clinical medicine is the symptomatology that results from ischemia of various organs. The pain in exercising muscles that are supplied by sclerotic arteries is well known as *intermittent claudication. Angina Pectoris* is a syndrome in an exercising heart that suffers from sclerotic coronary arteries. *Chemical changes in the blood,* such as increased *lactic acid* content can also reflect ischemia of muscles. There is a suggestion that *polycythemia* may in certain conditions result from ischemia of the bone marrow.

To this group we must now add hypertension which may reflect the existence of ischemia of the kidneys. Hypertension therefore may be a sign of renal ischemia much like angina pectoris is a symptom of cardiac ischemia.

That reduced blood supply to the kidneys causes permanent hypertension has been demonstrated by Goldblatt. This investigator placed adjustable silver clamps on the renal arteries and found that the animals invariably developed hypertension. There was an increase of both the systolic and the diastolic pressures and their level was a measure of the degree of constriction of the renal arteries. These experiments in dogs produced elevated blood pressures which are indistinguishable from the variety which we recognize as essential hypertension in man. The pressures could be varied only by varying the blood supply to the kidneys and by no other means; medicines and diet were ineffective. It was possible to obtain high arterial pressures for months without any other sign of renal disease. The kidneys did not lose the power to concentrate the urine, nor did the urine show albumin or casts. In other words, hypertension was the only sign of the existence of a renal circulatory impairment, while the height of the systolic and diastolic pressure was a measure of the degree of impairment of the renal blood flow.

The mechanism of the hypertension seems to be the entry into the venous blood from the ischemic kidney of some pressor substance which acts upon all the arterioles of the body, causing their constriction. Subsequent studies by Prinzmetal and his associates have shown that there is no loss of vasomotor control in the vessles, since they can still respond to dilator and constrictor influences.

Cutting nerve paths in no way alters the level of the blood pressure unless in some way the blood supply to the kidneys is increased by the surgical procedure. A point of extraordinary interest is that the whole disease is reversible when the clamps are removed and the blood supply to the kidney restored. This has directed clinicians' attention to the obvious conclusion that hypertension often may be the only sign of the existence of renal ischemia. Many cases may be expected as time goes on, which will prove clinically this experimental fact. One example is the hypertension in prostatic hypertrophy which often promptly subsides with decompression of the urinary tract. Here the mechanism of the hypertension can be considered to be the impaired renal circulation, caused by pressure upon the kidney substance from the pressure hydronephrosis.

Other instances of hypertension associated with diseases of the urinary tract will come to light once the thought is accepted that cases of hypertension with high diastolic pressures are probably of renal origin.

* * * *

THE COLLATERAL CIRCULATION TO THE HEART

Louis H. Nahum, M.D.,
New Haven, Conn.

We know already the grave consequences of ischemia of the heart, resulting from coronary artery sclerosis. The question remains regarding the mechanisms for collateral circulation that exist in the heart to offset the evil consequences of ischemia. Many studies have been made by generations of investigators. The old views that the coronaries are end arteries have given way to the more recent ones that collateral circulation in the heart does exist. But how the collateral circulation comes into being was more difficult to determine. If one should suddenly tie off a large coronary artery experimentally, death is fairly sudden, and no collateral can be found to exist of sufficient magnitude to prevent the death. Nevertheless, innumerable cases are found at autopsy in which coronaries are completely closed in hearts that had evidently been supplied with sufficient blood to remain alive. The answer to this apparent inconsistency appears to be that pathological closure of a vessel is often a slow process and that it is the slow development of the sclerosis that allows for the opening of collateral channels.

---

*Presented at the Clinical Congress of the Connecticut State Medical Society, September 19, 1939, New Haven.

The whole problem was studied recently by Schlesinger at the Beth Israel Hospital in Boston by a very ingenious technique. He injected the right coronary artery with a blue injection mass, and the left with a red one simultaneously. In this way he was able to study the distribution of the blood from the two coronaries and establish definitely whether they had developed collateral branches. He then cut the heart in a complicated way so that it could be spread out in one plane. The results were quite unexpected. Much collateral circulation was found, but only in hearts that exhibited various stages of sclerosis; he found practically no collateral circulation in normal hearts. The conclusion was unavoidable that only those hearts that need a collateral circulation develop it. In other words, sclerosis of the coronaries alone initiates the opening of collateral channels. The heart has a sort of self starting mechanism for collateral circulation, the signal being the onset of vascular sclerosis. Another important point emerging from this work, was that an infarct formed only after several arteries in its region had already closed. Clearly, infarction is a late stage in the development of coronary artery disease.

Clinical medicine is richer as a result of this study. Four types of patients suffering with coronary artery disease may now be recognized clinically and correlated with the pathological picture:

1. The patient who has gradually developed dyspnoea and precordial pain on effort, is one whose sclerosis is advancing faster than the collateral circulation in the heart. Such a patient may be expected sooner or later to develop coronary occlusion.
2. The patient whose cardiac symptoms are stationary is probably developing collateral circulation as fast as the sclerotic process is advancing.
3. The patient whose anginal symptoms improve, is developing collateral circulation faster than the sclerotic process is progressing.
4. The apparently well patient who suddenly develops cardiac pain or pulmonary edema has clearly suffered a sudden accident in the coronary tree. Even if the pain promptly subsides, he should be treated not for a "coronary spasm," but rather for a partial or a complete closure of a vessel. Immobilization by bed rest is imperative. The patients who die suddenly are those of this group who have had an unheeded premonitory pain or dyspnoea several days before death has occurred.

It is apparent that the search for methods to dilate the coronary arteries and facilitate the development of collateral circulation has by this work received a tremendous impetus.

* * * *

THE SENSITIVE CAROTID SINUS

Louis H. Nahum, M.D.,

New Haven, Conn.

The first knowledge which we have about the carotid sinus is an observation which Doctor Czermak made upon himself in 1866. Apparently he had a bulbous dilatation of the left carotid artery which, on compression caused a marked slowing of the heart and fainting. Because of the limited knowledge at that period he assumed the result was due to pressure upon the vagus nerve.

Since 1923, and more especially in the last few years, the function of the carotid sinus and clinical cases of carotid sinus senstivity have come more and more to light. Dr. Soma Weiss of Boston has reported a large series of patients with symptoms of carotid sinus sensitivity. The most striking one is that of a motorman who wore a high celluloid collar. For several months he suffered attacks of fainting when he turned his head to the right side, but as long as he looked straight ahead, he felt well. Examination by pressure on the right carotid sinus caused fainting, slowing of the pulse, and deep sighing respiration. He was advised to give up his celluloid collar and wear an open soft collar, following which he was relieved. A recent patient of mine, who was a gardener, noticed that when he stooped over he grew faint and his doctor observed a slowing of the heart and marked drop in blood pressure. The episodes could be reproduced at will by pressure over the right carotid sinus, but not over the left.

In elderly people, dizziness and faintness induced by stooping over or by suddenly rising up from the prone position, may be caused by a sensitive carotid sinus and they should be studied for this condition. An important component of this reflex is constriction of the cerebral vessels. Obviously, even slight changes in the cerebral circulation would produce marked symptoms in patients who already have some sclerosis of the cerebral vessels. It is therefore not surprising that the syndrome of carotid sinus sensitivity is the most common in elderly people. Whenever any patient complains of fainting or a feeling of faintness and dizziness, especially on change of posture or on twisting the head, the physician should suspect the presence of a sensitive carotid sinus in the patient and carefully examine him for this condition.

The technique of examination requires that the patient be sitting, since when lying down the reflex is not easily elicited. The sinus is at the junction of the internal and external carotid artery in the posterior wall of the artery. This junction is about on the level with the angle of the jaw. The artery is first palpated and the finger carried along it to the level of the jaw. At this level it is forced backward and compressed against the transverse process of the cervical vertebra. Sometimes just stroking is sufficient to induce the reflex. In patients with very sensitive carotid sinuses, the slightest pressure will slow and even arrest the heart. The patient may sweat, even lose consciousness, and exhibit deep sighing respiration.

When sensitivity is found, an appropriate dose of belladonna or atropine will lessen or even abolish it. In very severe cases, tumors of the carotid body have been found to impinge on the sinus, and have required surgical removal.

Since treatment with atropine is usually effective, the recognition of this disorder will provide a basis for a striking cure of an otherwise distressing and demoralizing ailment.

Following this presentation, a demonstration of the action of the carotid sinus reflex was given in which the rate of the heart was made audible by amplification of heart sounds.

* * * *

DIAGNOSIS AND TREATMENT OF PATIENTS WITH LOW METABOLISM

Edwin F. Gildea, M.D.,

New Haven, Conn.

The basal metabolic rate has not proved to be an infallible criterion of hypothryoidism. For example it may be low without the syndrome of sensitivity to cold, edema, dry skin and coarse hair, or the patient may be so tense and excitable that relaxation essential to the measurement of the true basal metabolic rate is impossible. Consequently it is difficult to make a diagnosis of hypothyroidism in many of these borderline conditions. As a result many patients without thyroid deficiency are given thyroid and are either not benefitted or in some instances harmed by increasingly large doses.

In the search for additional criteria of thyroid deficiency we have studied, in addition to the basal metabolic rate, the blood serum cholesterol, titrated fatty acids, lipoid phosphorous and total proteins at frequent intervals in 29 patients before, during and after treatment with thyroid. Five of these patients had most of the classical symptoms of myxedema including basal metabolic rates below minus 20 per cent. Striking clinical improvement followed the administration of 1-2 grains of thyroid per day. The second group of 11 patients included people with most of the symptoms of myxedema, but who either did not have basal metabolic rates below minus 20 per cent or had complicating disorders. Thyroid treatment in small amounts, 1-2 grains, was followed by recovery. A third group included patients with only some symptoms suggestive of myxedema but with basal metabolic rates below minus 20. Administration of thyroid even in doses of 4-5 grains daily produced no more improvement than did subsequent administration of placebo. In the fourth group were six patients with multiple complaints and particularly incapacitating weakness. Their basal metabolic rates ranged from minus 10 to minus 19 per cent. They experienced no or only slight subjective improvement on thyroid administration.

A comparison of the results of these studies on the four groups of patients yielded the following conclusions:

1. The levels of serum cholesterol, phosphatides, and fatty acids are readily affected by changes in the amount of thyroid hormone in the body.

2. Patients with myxedema have remarkably high serum lipoids (cholesterol 335 to 603 mgms. per cent). Amelioration in symptoms by administration of 1 to 2 grains of dessicated thyroid is closely paralleled by a fall in lipoids and a rise in basal metabolic rate. The lipoids revert to former high levels with return of symptoms following omission of thyroid therapy. In patients without hypothyroidism thyroid lowers serum cholesterol, but the decreases are not so significant and larger amounts are required.

3. The level of serum cholesterol is a useful tool in determining the presence or absence of hypothyroidism. A serum cholesterol below 275 mgms. per cent practically excludes hypothyroidism, and indicates that the administration of thyroid will probably have little or no effect in relieving symptoms.

4. Although the combination of high cholesterol and low basal metabolic rate may be the result of conditions other than hypothyroidism, patients with these findings should be considered as having hypothyroidism until the contrary is proven by their failure to improve after treatment with thyroid.

5. Serum proteins tend to lie above or in the upper part of the normal range in hypothyroidism. The level of proteins could not be consistently corrleated with the amount of edema. In many of these patients nutritional and metabolic factors appeared to be more important than changes in water balance in determining proteins.

We wish to stress, therefore, the value of blood serum cholesterol measurements in determining the presence or absence of thyroid deficiency.

It is also important to remember that patients who do not have thyroid deficiency are rarely if ever benefitted by the administration of thyroid, that patients may be seriously incapacitated by large doses, and finally that people with true thyroid deficiency can be relieved of symptoms by small doses of thyroid usually 1 to 2 grains daily.

* * * *

VITAMIN K IN BLEEDING DISEASES*

Martin Heinemann, M.D.,
New Haven Conn.

A fat soluble dietary factor has been named by Dam of Copenhagen vitamin K because it promotes the coagulation of blood (in Scandinavian languages, coagulation is written with a capital K). Further investigations established more specifically that the formation of prothrombin is correlated to vitamin K. Chemically, this vitamin has not yet been identified; it is free from nitrogen, phosphorus and sulfur. Tests for vitamin K depend on the indirect measurement of the amount of prothrombin in a given sample of blood. The critical level of prothrombin at which bleeding danger becomes manifest is at about 30 per cent of the concentration in normal blood. Considerable variations have been observed, however, and ascribed to the limited reliability of the methods employed. Widely used is the method of Quick (J. Am. Med. Assoc., **110,** 1658, 1938). Oxalated plasma is treated with an excess of thromboplastin and an optimum amount of calcium. The only variant remains the prothrombin originally present. Differences in clotting time of plasma under the conditions of this method — called the prothrombin clotting time — are considered as indicating differences in the concentration of prothrombin. Another method for prothrombin used by Dam utilizes tissue extract and heparinized blood plasma. The following table may be of some help for discussing the different ways in which vitamin K deficiency can develop.

The presence of bile salts in the intestine is essential for absorption of vitamin K. In the liver, vitamin K is believed either to be necessary for proper function of the cells, as the result of which prothrombin is formed, or it is considered to be an important building stone for this substance. By administration of bile salts alone prothrombin levels and clotting time have been influenced favorably in cases of obstructive jaundice where vitamin K absorption is inadequate or lacking. Still better results were obtained with vitamin K given simultaneously. Recently vitamin K emulsions for intramuscular injection have been prepared and used with considerable success. Preparations for parenteral use would be required, for example in cases of extensive ileitis where — with or without bile — damage of the intestinal wall prevents vitamin K absorption. But even following injection, an effect upon the prothrombin formation can be expected only if the liver is not damaged too severely. In one case of cirrhosis and in one case of syphilitic Banti with greatly impaired liver function, injection of vitamin K was without any effect.

---

*From the Department of Internal Medicine, Yale University School of Medicine, New Haven.

It is evident that vitamin K can exert no clinical effect on bleeding when the prothrombin level is not abnormal. Thus, in hemophilia, macrocytic anemias and essential thrombopenia, vitamin K therapy is not indicated since prothrombin has been found to be normal in these diseases. The observations in this group of diseases support the probability that prothrombin is formed in the liver and not in the platelets as had been suggested for some time.

Vitamin K is found in most of the green vegetables. Very good sources are spinach and cabbage; tomatoes and hog liver contain considerable amounts. On the basis of experimental evidence presented by Almquist, it has been concluded that vitamin K can be formed from precursors by the action of bacteria in the human intestine. The sterile intestine of newly born infants has been cited as cause for low prothrombin levels observed immediately after birth. The ingestion of food with its associated bacteria would cause the formation of vitamin K in the intestine of these infants and is held responsible for the rise in prothrombin-concentrations noticeable at about the fourth day. In cases of traumatic bleeding in the newborn, clinical and laboratory improvement have been reported following administrations of vitamin K. Whether prophylactic treatment of mothers before delivery can prevent these low prothrombin levels and reduce the danger of bleeding is at present under investigation.

Briefly summarizing, we find vitamin K treatment indicated where low prothrombin levels are present or imminent. Its administration seems definitely indicated in obstructive jaundice; it can be considered in conditions where widespread intestinal damage prevents its absorption.

Treatment of the new born may also be indicated.

* * * *

SPECIFIC VERSUS MIXED THERAPY IN VITAMIN B DEFICIENCY*

Martin Heinemann, M.D.,
New Haven, Conn.

The term vitamin B complex comprises three groups of substances:

1. chemically isolated constituents of known importance for human nutrition;

2. substances probably influencing human disease, but not yet isolated;

3. a group of substances important for certain species of animals only. This third group and investigations on animals will not be considered here.

To the first group belong: thiamin, nicotinic acid, riboflavin and B_6. Under certain conditions, each one of these substances can produce rather specific effects. The conditions suitable for recording characteristic effects of single substances are rarely met in human pathology. Isolated deficiency in riboflavin, for example, which causes certain lesions of the skin, has been observed only after prolonged use of an experimental diet and will hardly occur spontaneously. Commonly, we find a more general nutritional disorder. But even in outspoken cases of pellgara where nicotinic acid is most effective, associated polyneuritis responds promptly to the anti beriberi vitamin thiamin and not all at to nicotinic acid. This combined treatment with nicotinic acid and thiamin does not yet give complete success. Spies has shown that the general condition and certain skin lesions of patients successfully treated for pellagra with both nicotinic acid and thiamin could be improved definitely by riboflavin. Other symptoms like nervousness and insomnia still persisted and would yield only to additional treatment with B_6. In the example of pellagra the effects of these four different substances could be recorded separately and rather safely; each one of these substances relieved definite manifestations in these patients. The situation is more complicated when we consider a group of patients more commonly met in this part of the country, in whom observations similar to the ones just reported have been published. Borsook and others have studied carefully about 250 patients with functional gastric disorders. As you know, nicotinic acid is of some help in a certain per cent of this group. But it follows from Borsook's study that the whole B complex is superior therapeutically not only to nicotinic acid but to any single one of the other fractions. Unless the deficiency in nicotinic acid is very marked, yeast extracts proved very satisfactory for the treatment of these patients.

---

*From the Department of Internal Medicine, Yale University, School of Medicine, New Haven.

The report on these two papers, the results of which have been substantiated by others, sufficiently demonstrates the difficulty of our problem: specific versus mixed vitamin B therapy.

Considering the advantages of administration of whole B complex we would agree that it is less expensive than a combination of pure substances. The presence of all the constituents seems to guarantee success no matter what kind or combination of deficiency prevails. This statement, however, is not true entirely and it has already become necessary to discuss disadvantages. It is impossible, for example, to supply nicotinic acid in *curative* doses (500 mg. daily given in divided doses) by prescribing yeast extracts in amounts which can be taken by human beings. The concentration of nicotinic acid in these extracts is too small. Yeast extracts appear, therefore, to be of greater value in preventing deficiencies than for their treatment. They also will be found helpful where therapeutic successes with pure substances remain incomplete. They do not permit, however, any therapeutic tests; regardless how striking their effect may have been, there will be no retrospective diagnostic hint. Experience with yeast extracts only can not satisfy those among our colleagues who want to enrich their experience in the field of nutritional disorders. For scientific purposes, the influence of whole B complex should be and actually is investigated only after having separately recorded the effects of the known substances first. Practically, with patients presenting themselves for diagnosis and treatment which will bring quick success, this ideal can be fulfilled only in a few exceptional cases. As is so often the case, the answer to our problem must remain an individual one and it can not be free from compromise dictated by necessity of circumstances.

* * * *

IN WHAT CASES SHOULD ONE EMPLOY PROTAMINE INSULIN?

Paul Lavietes, M.D.,
New Haven, Conn.

Protamine insulin, properly used, is a valuable addition to the therapy of diabetes. Used in improperly selected and poorly controlled patients, it may do much harm. Some effects of protamine insulin may be demonstrated under special circumstances for over 48 hours. In fact, its greatest effect on the blood sugar may be apparent after 24 hours, probably not because absorption is greatest at that time, but because this usually coincides with the end of the overnight fast. It has now been shown beyond doubt that except in the mildest cases protamine insulin has little or no effect on postprandial glycosuria and hyperglycemia, and that its major effect is in a gradual reduction of the blood sugar during the overnight period when no food is taken. This is true regardless of the time of day the insulin is given. By many the use of the old insulin has been abandoned except as an adjunct to protamine insulin. In my estimation this is an unwarrranted position. First, to clarify my position, let me say that the treatment of diabetes is concerned with supplying adequate nutrition, and insuring the utilization of food with a minimum of interference with the patient's normal mode of life. Nothing has been said about the blood sugar because there is no evidence that elevation of the blood sugar in itself has any deleterious effect. Glycosuria, on the other hand, is definitely harmful because it results in impairment of nutrition and dehydration. If a patient, given an adequate diet, shows no glycosuria in any specimens, not just in the fasting specimen, there is no indication for protamine insulin or any other insulin. If the patient shows glycosuria during the day which disappears or lessens overnight, the glycosuria is usually better controlled by a single dose of regular insulin given before breakfast than by protamine insulin. As with normal subjects, the tolerance for carbohydrate is lowest in the morning. The regular insulin given before breakfast is sufficient to prevent glycosuria at this time and the patient's native ability to utilize carbohydrate serves to prevent glycosuria through the rest of the 24 hours. If protamine insulin is given in such cases, glycosuria after meals may not be prevented and still the patient may go into shock before breakfast the next day. In the cases in which glycosuria can not be controlled throughout the 24 hours with a single morning dose of regular insulin, an evening injection can usually be avoided by giving protamine insulin together with a small dose of regular insulin before breakfast. In few, if any, of such cases can protamine insulin alone substitute for 2 daily injections of regular insulin. The protamine and regular insulins can be drawn into the same syringe and given as a single injection without any loss of efficacy. Protamine insulin, then, finds its true usefulness in patients in whom it proves possible to control glycosuria with regular insulin only if 2 injections are given daily. It has been our practice first to treat every patient in whom glycosuria does not subside with diet restriction alone with regular insulin, never to start with protamine insulin. If it is then found that the patient, while undertaking his usual activities, still requires more than one dose of insulin, a transfer is made to a mixture of protamine and regular insulin given before breakfast. To begin with, the total dose given is about four-fifths of the regular insulin requirement; of this, only 10 to 20 units need be regular insulin. Then, the dose is adjusted to control glycosuria by finding the smallest does of protamine insulin necessary to prevent glycosuria in the urine voided between arising and breakfast and the smallest supplement of regular insulin which will control glycosuria through the day. The before breakfast specimen is used instead of the overnight one since the latter may contain sugar voided early in the night even when there is hypoglycemia before breakfast. Whenever possible a small carbohydrate feeding is supplied between breakfast and lunch and a larger one at bedtime in order to forestall hypoglycemic reactions. It is also well, for the same reason to request the patient to take his breakfast fruit immediately after arising. I have attempted to indicate roughly that while protamine has a very useful place in the treatment of severe diabetes, it probably has no advantage, and many disadvantages in the great mass of milder cases. Chief among these is an increased frequency of hypoglycemic reactions.

* * * *

CORTICO-STERONE, ITS CLINICAL USES.

Paul Lavietes, M.D.,
New Haven, Conn.

There is no evidence that adrenal cortex extracts in doses of less than 10 cc. daily have any effect in Addison's disease. Since 10 cc. costs three dollars at present, the clinical use of such extracts is impractical. Fortunately, most patients can be maintained in good condition without extract by the use of large amounts of salt.

The latest addition to the therapy of Addison's disease is desoxycorticosterone, a synthetic preparation which has properties similar to those of natural cortical extracts. This product is potentially more available and less expensive than the extracts. The dose as reported in preliminary trials varies from 1 to 10 mg per day. The substance is very sparingly soluble in water, and is therefore prepared in oil for subcutaneous injection. The most recent development takes advantage of this insolubility in aqueous media. Sterile pellets weighing 50 to 100 mg. each when inserted into the subcutaneous tissues have been found to dissolve at a fairly steady rate of 0.25 to 0.35 mg. per day. Thus 3 or 4 pellets would be expected to supply 1 mg. daily for approximately 1 year. The requirement is first determined for each patient by the use of the oil solution of the substance. Excessive doses have produced alarming anasarca which required treatment with salt-free diet and diuretics. There seems every reason to believe that this new therapeutic agent will prove very useful in the treatment of Addison's disease. It seems wise for the present at least to restrict its use, however, to carefully controlled cases because over dosage may have the serious consequence noted above, and it is possible that even moderate doses may suppress regeneration of native adrenal function. Corticosterone will undoutedly be recommended for a variety of conditions other than Addison's disease. Chief among these are those conditions in which asthenia is a prominent symptom. Since in such conditions, suggestion often plays a prominent role, subjective improvement after the injection of corticosterone, or cortical extract, can hardly be taken as an indication that adrenal deficiency has actually been present. It would seem more rational, and much less expensive, to try the effect of large amounts of salt, since even in outspoken Addison's disease asthenia can be markedly improved by this procedure.

* * * *

IS THERE AN IODINE-FAST STATE?

Paul Lavietes, M.D.,
New Haven, Conn.

If iodine is given over a long period to a patient with hyperthyroidism, the metabolic rate usually increases after a variable time. This has given rise to the impression that the effect of iodine is transitory, and, that it should, therefore, be used only in preparation of the patient for operation. This is disputed by some who have used it over long periods with continued good results. The degree of relief is variable, rarely complete. In every clinic some patients have been permanently improved or apparently cured by the prolonged use of iodine. Furthermore, when iodine is withdrawn after relapse, the metabolic rate rises sharply, sometimes alarmingly to fall again when iodine is resumed. Obviously the iodine is still exerting its effect. It is the disease which is changing, not the influence of iodine. Untreated hyperthyroidism runs a cyclical course with alternating exacerbations and remissions, and spontaneous cures are not uncommon. Iodine appears only to modify this course, its immediate effect depending on the trend at the moment. During an exacerbation its apparent effect may be nil; during a remission it may seem to be particularly efficacious. The apparent state of refractoriness to iodine represents merely the intervention of a fresh exacerbation. This purely empirical explanation, set forth by Dr. Means and his collaborators seems to be at least consonant with the facts.

This concept of a lasting effect of iodine on the course of hyperthyroidism has many obvious clinical implications. It now seems justifiable under circumstances in which thyroidectomy seems inadvisable or impossible to give iodine for prolonged periods. It may even be justifiable to try to avoid the need for operation in certain cases by the prolonged use of iodine. I must caution, in closing, however, that before iodine is given, observations of clinical condition, basal metabolic rate, pulse and weight be carefully recorded to avoid later confusion in diagnosis if and when operation must be considered. The use of iodine over long periods is perhaps especially justified in the management of thyrotoxicocis persisting after thyroidectomy and in mild recurrences of thyrotoxicosis.

* * * *

RENAL STONES

Clarence Robbins, M.D.,
New Haven, Conn.

The well established principles of in vivo solution of renal calculi may be briefly stated as follows:

First, insofar as possible reverse the underlying metabolic or anatomic fault which favors stone formation. Hyperparathyroidism is an excellent example. It is futile to direct treatment toward removal of the renal stones until we have corrected the metabolic disease which yields the excess calcium and phosphorous excretion in the urine. The dramatic success of proper treatment of this condition makes it particularly important that no case be allowed to go unrecognized. Every case of calcium stone should be promptly investigated for hyperparathyroidism. Obstructions in the urinary tract which cause stasis of urine must of course be removed before we can expect any success in dissolving stones. Likewise infection, although the best authorities feel that it may not be an important causative factor in stone formation, is an important complicating factor in treatment. It is useless and, as we shall see, even dangerous to try to acidfy urine in the presence of a heavy infection with urea splitting organisms such as B proteous and maybe some of the staphylococci. Every effort must be made to combat infection along with the regime of dissolving.

The second principle in medical management of stone cases is simply—to maintain that reaction of the urine, depending on the chemical nature of the stone, which will favor the solution of its chief constituent salt.

Although pure stones (that is composed of only one salt) are relatively uncommon it is usual for one salt to predominate and that is the one for which we must find a suitable solvent. Fortunately the x-ray helps us in the identification when fragments of the stone may not be available for chemical examination. Failure of stone to show in the roentgenogram is strong evidence in favor of a uric acid stone. Staghorn stones are nearly always either calcium phosphate or cystine. The latter stones occur with cystinuria so the diagnosis can be easily ruled in or out by testing the urine for cystine. (To 5 cc. urine made alkaline with NH_4OH add 2 cc. of 5% sodium cyanide solution; allow to stand 10 minutes; add a few drops of a freshly prepared 5% sodium nitro prusside solution; in the presence of cystine a deep purplish red color will develop and remain.)

It is probably improper to speak of a stone as composed of calcium phosphate — it is much more likely that the calcium salt is a complex one with carbonate and phosphate radicles in the same molecule. Fortunately it is not important in treatment. Any calcium stone may be assumed to dissolve more readily in acid solution than in alkaline. Uric acid stones and cystine stones will dissolve in alkaline solutions.

The adminsitration of sufficient alkalis by mouth to maintain the urine pH at a physiological maximum of 8/0 is simple enough and the results in cases of uric acid stones are usually gratifying.

It is not so easy to dissolve the calcium stones. We can maintain the reaction of urine at 5/0 which is close to the physiological limit by the continuous administration of acidifying salts but at the same time we are dissolving calcium and phosphate out of the bones and significantly increasing the renal excretion of the very ions that we seek to dissolve away from the surfaces of the stone. This fact accounts largely for the disparity between in vitro and in vivo results with calcium stones. The acidifying regime is not useless but it is limited in value. It would seem unnecessary to recall that the greater the volume of urine the greater its solvent properties. A dilute urine does not preclude a very acid urine. It would also seem unnecessary to mention that phosphate salts for acidification are distinctly contraindicated because of the common ion effect. The best acidifying agent is probably ammonium chloride; it is available in several preparations that obviate gastric irritation. The preference of some urologists for hydrochloric acid has, in my opinion, little justification. Seven capsules of NH_4Cl of 7½ grs. each yield approximately 1/16 molecular weight or 2/1 grams of chlorid ions. The ammonium ions are promptly converted into urea within the body and hence play no part in the acid base balance of the urine. The chloride ions produce an acidosis which calls forth all the buffering mechanisms of the body including a shift of the urine pH to its most acid limit. In order to achieve a similar degree of acidosis with hydrochloric acid the dose must be 20cc. of the dilute U.S.P. preparation, a somwehat larger dose than most patients can tolerate.

It is extremely important that we know the approximate pH of the voided urine when a patient is being acidified. It not infrequently happens that urea splitting organisms in the kidney pelvis produce so much ammonia that acid urine entering the pelvis is promptly neutralized or even alkalinized. The excess calcium which was contributed by the bones as a buffer against internal acidosis then precipitates and the stone actually enlarges. If the freshly voided urine cannot be kept at a pH of 5.5 or below as tested by nitrazine papers then we are doing distinct harm by our acidification regime and it should be stopped at once.

In the past few months a new procedure is reported from the Stone Clinic of the Massachusetts General Hospital. It can scarcely be called a purely medical method because it requires the special techniques of the urologist. In principle the method employs a solution for bathing the stone "from below" through cystoscope, ureteral catheter or nephrostomy tube — the solution being of such composition that the calcium ions dissolved away from the stone are "fixed" in solution. For this purpose a solution of citric acid has been selected. The following equation illustrates the principle.

$$3\,Ca^{++} + 2\,Cit = \longrightarrow Ca_3\,Cit_2 \longrightarrow Ca^{++} + 2\,(CaCit)$$

The net result of adding citrate ions to a solution containing Ca ions is to divide the number of Ca ions by 3.

It should be emphasized that this equation holds only at alkaline pHs; at the acid pHs necessary to initiate the solution of the stone the calcium fixing power of citrate is less than 2 out of 3 — still enough of the property is retained to be significant.

The citrate solution which has been used has a pH of 4.0 and a concentration of citrate which is twice isotonic. Its formula is:

Sodium citrate	45.2 gm.
Citric acid	38.0 gm.
Distilled water to	1000 cc.

In vitro experiments have been most encouraging and likewise the few clinical cases up to date suggest that the procedure is valuable.

Most recent experiments indicate that hexametaphosphate is even more successful than citrate in fixing calcium ions in solution. No clinical reports of its use are as yet available.

☆☆

ALL THIS IN HARTFORD

It is our friend, Mrs. P., and her kind who supply the lighter touches that help balance the budget. When the doctor told her the baby had rickets she stated indignantly that she didn't mind the twins having worms but the baby having "crickets" was just too much. She insisted her husband did not own the family car and, to prove it, she would show anybody her brother-in-law's "restoration" card. At Easter she guessed the twins would have to be bought new "outlets." Her husband only the other day had been asked to be a "pall bearer" for a funeral. Recently on announcing with joy that her husband had a good job in Hartford, where they could live in "lux" but were sure they could get by, she stated she would no longer be bothering us. I assure you her gain is our loss. We shall miss her!

The Child, Jan. 1940

☆☆

NUMBER OF PHYSICIANS IN U. S. INCREASED BY 1,379 IN 1939

A deduction of the number of obituaries of physicians published in 1939 in *The Journal of the American Medical Association* from the number of graduates of medical schools for the fiscal year ended June 30, 1939, reveals a net addition of 1,379 physicians to the profession during the year, not including those coming to the United States from abroad, *The Journal* points out in its annual analysis of physician mortalities.

"The number of obituaries of physicians published in *The Journal* during 1939 was 3,879, of which 3,710 were of the United States and 169 of Canada," the analysis says. "Three died in Hawaii, three in China, two each in France and the Philippine Islands, and one each in the British West Indies, Canal Zone, Egypt, Germany, Mexico, Persia and Puerto Rico. The obituaries of 116 women physicians were published, as compared with 108 in 1938.

"The average age at death of those classified as of the United States was 66.1, as compared with 65.6 in 1938. Heart disease was again the leading cause of death, as it has been for many years."

The PROFESSIONAL EQUIPMENT Co.
X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS.
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

Prophylactic Removal of Rectal Polyps*

SIMON B. KLEINER, M.D.,
New Haven, Conn.

In the course of routine procto-sigmoidal examinations, small polyps, of either the sessile or pedunculated type, are very often encountered. There is a great temptation, especially if pathological examination, following biopsy, shows absence of malignancy, to allow these polyps to remain in the bowel. The following cases are presented to emphasize the fact that we should not be persuaded to follow less radical procedures because of the serious consequences of leaving these apparently benign lesions alone.

Case 1. A man 65 years old was referred to me March 31, 1930, with the complaint of prolapsing piles. He complained mainly of a mass which prolapsed on bowel movement and which was easily reduced. Bleeding was not pronounced, the only blood observed being some staining of the toilet-paper with which he replaced the protusion.

Digital and sigmoidoscopic examination showed a movable pedunculated mass on the posterior wall of the rectum 9 cm. above the anus. The mass was smooth, of soft consistency, and was apparently a pedunculated polyp about 4 cm. in diameter. Consultation with the family surgeon was requested by the patient. X-ray examination failed to show the polyp but showed some diverticulitis. The surgeon advised against removal of the mass and the patient was told to return for examination at six month intervals.

However, the patient failed to return until July 30, 1937, at which time he complained of severe anal pain and slight bleeding and protrusion from the anus. His bowel habit had changed from normal bowel movements to obstinate constipation. Inspection showed a posterior fissure which accounted for his pain. Further investigation revealed a cauliflower-like indurated mass on the right posterior rectal wall, which extended around anteriorly and was fixed to the prostrate. It was located at the same level above the anal margin as the lesion already described. A biopsy was taken and the specimen was reported to be adenocarcinoma, grade II.

He was referred to his general surgeon and on August 8, an exploratory laparotomy was performed which showed metastases to the liver and seed metastases in the pelvis. A colostomy was done but no resection attempted. He was discharged August 28, 1937, to his home where he died six weeks later. No autopsy was obtained.

Case 2. A male 64 years old was in an institution for manic-depressive insanity, and was referred to me October 12, 1931. At that tme he had bleeding stools which had been noticed for one day, but as his hemoglobin was 35% and his red blood count 1,000,000, this bleeding had probably been going on for some time.

A sigmoidoscope was passed to 22 centimeters and at 16 centimeters there was an ulcerated area about 2 centimeters in diameter with raised edges. There was no induration. A diagnosis of possible beginning malignancy was made. No biopsy was taken at this time. No barium enema x-ray was taken as there was no apparatus available at the institution. The possibility of operation was considered, but it was felt that any major procedure might cause the man's condition to change from a state of depression to one of excitement and complicate his convalescence considerably. He was seen again a year later, on September 23, 1932, at which time he had gained 29 pounds, which seemed to mitigate against a malignancy.

At this time there was a movable mass on the right rectal wall about 14 centimeters above the anus and this was now large enough to permit a biopsy to be taken. The diagnosis of the pathologist was benign hyperplasia of the rectal mucosa. Because of the bleeding he was treated fortnightly for several months. On May 1, 1933, another biopsy was taken and this showed a characteristic pathological picture of carcinoma of the rectum of the glandular type. He continued to have bleeding with occasional cramps and with considerable mucous in the stools. The mass became larger but no metastases could be found. On May 24, 1935, he had a coronary attack and following this there were several similar episodes followed by his death on August 27, 1935, four years from the time I first saw him. The cause of death was coronary occlusion. Post mortem examination was not permitted.

It is recognized that in relating these two cases no particularly new idea is presented; however, the fact that there was an opportunity of watching these two malignancies develop has very strongly impressed me with the point made by various authors, including Buie, Lockhart-Mummery, Bacon, Hayden and many others — that all polyps should be removed. Cattell of Boston also emphasized this very point in a recent paper presented before the New Haven Medical Society.

(*Continued on Page 271*)

---

*Read at the meeting of the New England Proctologic Society, Bridgeport, October 13, 1939.

The Premonitory Symptoms of Acute Coronary Thrombosis

EDWARD GIPSTEIN, A.B., M.D.
New London, Conn.

We recognize the value of a properly taken history, and appreciate the necessity of obtaining all the essential facts in order to evaluate any given case. That this applies particularly so to a patient with coronary artery disease is quite obvious. Since coronary artery disease is so prevalent today, and since the acute occlusion of a coronary artery is an every day occurrence, it behooves us to acquaint ourselves with every detail and scientific fact pertaining to this malady. It is not the purpose of this brief paper to enter into a discussion of the value of adequate and reliable histories or the method of securing them, but to stress the fact that prior to the occlusion of a coronary vessel certain symptoms do exist in a large percentage of cases.

In the past when coronary artery occlusion was not so easily recognized, many clinicians did not even mention the premonitory symptoms of acute coronary thrombosis. Only in rather recent times has the importance and significance of these symptoms been appreciated and studied. Brill in his monograph on coronary artery disease and angina pectoris states that the occurrence of substernal or epigastric pain may precede by hours or days the onset of acute coronary occlusion. He also adds that "this differs from the typical anginal pain, from which the patient may or may not have suffered in the past, in that it is usually milder, is not related to effort, is more prolonged, and does not significantly respond to nitrites." The objective findings usually present in actual occlusion are absent. Herrick, Connor and Holt, Parkinson and Bedford have all described the transitory pains in the chest that have preceded an acute occlusion. Levine states that "on close questioning many patients will confess that during the preceding day or two they had not felt quite well, and may have more or less milder discomfort in the chest."

It has been the experience of the writer that the majority of the cases of acute coronary occlusion do reveal, when questioned carefully, certain premonitory sensations that have been present a day or two or even a week prior to the acute episode. In one a peculiar discomfort or heaviness in his chest; in another a vague disturbance of respiration or shortness of breath; in a third a distressing feeling in his upper abdomen in the region of the epigastrium; and in others a muscular weakness or malaise. That some may experience actual pain long before the thrombosis is not denied. Rarely, although this is the common conception, does an acute coronary episode strike as a bolt from the blue. It is quite true that most patients attach little if any importance to their state of health a few days before the agonizing substernal pain strikes them. They usually forget or disregard these premonitory sensations and state that they were in perfect health until their attack. Of course, this does not apply to that group of cases who experience angina pectoris, which in a great majority of individuals has been present for some time before an attack of acute coronary thrombosis has occurred.

It is a common characteristic of the average patient to overlook almost all sensations that are not productive of pain, and since so many cases before an acute occlusion do not reveal actual pain, it is easily understood why the all-important symptoms prior to a coronary thrombosis are not mentioned by the patient. Whether or not the detection of these premonitory symptoms would forestall the acute episode is a moot question. In some instances bed rest for a few days or cessation of strenuous activities and prevention of emotional outbursts might render the patient less susceptible to an acute attack.

The important fact is the recognition of the existence of these symptoms. By carefully analyzing the history of these patients and the detection of those vague sensations that are experienced, we might gather valuable knowledge as to the mechanism and factors that enter into the production of acute coronary thrombosis.

☆☆

PROPHYLACTIC REMOVAL OF RECTAL POLYPS

(*Continued from Page* 269)

In the first case the suggestion of surgical intervention was overruled by the surgeon. In the second case, as related above, careful consideration was given to the question of removal, but because of the mental condition of the patient we decided against that course. Every proctologist naturally is confronted with cases of this type frequently, and probably every once in a while we are tempted to be conservative. This brief paper is an attempt to again persuade the profession to keep on being radical in the treatment of polyps.

Buie once referred to all rectal polyps as "sentinel polyps." While I believe that he meant to point out that when a polyp is seen, one should always try to rule out the presence of a neoplasm higher up, nevertheless, it might be a good plan, in calling these lesions "sentinel polyps," always to remember that their presence is a source of danger because of the very real possibility that they may degenerate and become malignant.

☆☆

SOLDIER'S IDENTIFICATION TAGS

"The identification tag that every soldier in the German army must wear around his neck will henceforth indicate the blood group to which he belongs (information necessary for blood transfusions)," the regular Berlin correspondent of *The Journal of the American Medical Association* reports in the Feb. 24 issue.

Compliments

of a

Friend

GREETINGS . . .

THE NEW HAVEN

DRUGGISTS

ASSOCIATION

A. B. LANDRY
President-elect

C. BARKER
Executive Secretary

J. I. LINDE
President

J. D. GOLD
Chairman Council

C. E. SANFORD
1st Vice-president

J. R. MILLER
Treasurer

W. B. WALKER
2nd. Vice-president

OFFICERS

Connecticut State Medical Society

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD
Stanley B. Weld, *Editor-in-Chief,* Hartford
Sidney G. Davidson, New Haven
Frank Stafford Jones, Hartford
Charles Mirabile, Hartford
Oliver L. Stringfield, Stamford
Herbert Thoms, New Haven

COUNTY NEWS EDITORS
Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

HARTFORD ONCE AGAIN

The Capitol City welcomes you for another annual meeting. One hundred forty eight years is not an unusual age for any organization to attain within the borders of New England or southward to the Old Dominion State, yet there are but few medical societies boasting longer life of continuous activity. The Hartford of today bears little resemblance to that of a century and one-half ago, indeed, so many changes have been fraught on the landscape even since the middle of the last century that our oldest member must at times be constrained to rub his eyes to assure himself that what he perceives is real.

In 1847 and 1849 the Connecticut Medical Society convened in Gilman's Hall, two years later, according to the "Proceedings," ineptly called Gilman's Saloon, the building still standing next to the Sisson Drug Company (see frontispiece). Those meetings were likewise held in May. The treasury in those days seldom held over $1,000 and the veracity of the County Association clerks or their ability as collectors would seem to bear a little scrutiny from the entry found each year, "Due from Clerks, supposed to be good." Most of the two days was consumed with the business of the Society and for the scientific session one finds a single "dissertation" read before the assemblage. Many names come down to us from those days, — Archibald Welch, George Hawley, Gurdon W. Russell, Eli Ives, Joseph Porter, Joseph Comstock, Elijah Middlebrook, Asa Witter, William Buel, John S. Peters. As George Sumner in his histological address in 1851 reminds us, "their professional labors are ended — not one remains to tell us how they strove to improve the character, and raise the standard of our profession — to diffuse medical knowledge, and to resist the unblushing assaults of ignorance and pretension."

From such simple beginnings we arrive at the complex program of the 148th Annual Meeting. A panel of eminent visitors invited to discuss a particular subject each day. Section meetings throughout each afternoon to carry on the theme of the morning. The House of Delegates convening on a separate day prior to the scientific session, thus completing the full program of the State Medical Society today.

* * * *

MORE LIGHT ON CANCER

In his recent talk at the last Clinical Congress in New Haven and in his various writings, Doctor W. Cramer of the British Cancer Commission has pointed out new facts based on clinical and experimental investigations that will not only profoundly affect our search for the etiology of cancer but will also indicate new methods by which cancer may be eradicated.

1. He has shown that cancer is not an autonomous growth, and that it probably takes about one-fifth of the normal span of human life before carcinogenic agents produce demonstrable cancer.
2. He has shown by experimental work on animals and clinical investigation that undoubtedly a susceptibility to the formation of cancer in particular organs and tissues is inherited by certain families and races.
3. Doctor Cramer has proved that not only do the tissues that already show hyperplastic changes, such as in warts, nevi, moles, erosions, ulceration etc., give rise to a higher incidence of cancer, but likewise the tissues that show hypoplastic changes are fertile field for the formation of cancer when stimulated by carcinogenic agents.
4. He points out that there are not only extrinsic carcinogenic agents, such as heat, infection, chemicals, pressure etc., but also there are intrinsic factors that play just as important a part in the formation of cancer. These intrinsic agents are physico-chemical reactions caused by the internal glandular secretions, which secretions are either building up tissue or causing atrophy. Some of the glandular secretions work with one another to accomplish the same purposes and are called synergistic secretions, while others are antagonistic. For instance, animal experimentations show that estrin and the secretion from the cortex of the adrenal work together while the thyrotropic hormone of the anterior pituitary gland is antagonistic to estrin.

If these facts and theories of Doctor Cramer's are true, it would seem that the State Medical Society and the State Tumor Committee would be justified, not only in advocating the yearly physical examination for the prevention of disease and for recognizing cancer in its incipiency, but in asking the physicians of this state to accept standard history forms and physical examination forms which would bring out all the detail that is necessary for ferreting out family susceptibilities to various forms of cancer and which would properly evaluate the various suspected carcinogenic agents as a probable inciting cause of these cancers.

Doctor Cramer makes a plea that America take up this work where Great Britain for the time being is forced to leave off. It would seem that Connecticut would be an ideal place in which to carry on these important investigations.

C. L. L.

* * * *

THE PROBLEM OF LOW BACK AND SCIATIC PAIN

A Consideration of Present Trends.

Low back pain may be a primary symptom of such varied conditions as pelvic inflammatory disease, prostatitis, diseases of the urinary tract or rectum, traumatic, neoplastic or inflammatory involvement of the spine or its supporting structures, diseases of the sacroiliac joint and functional or structural anomalies of the lower extremities. Between 1910 and 1930 considerable attention was devoted to diseases of the sacroiliac and lumbosacral joints. Smith-Peterson in 1924 discussed the lumbosacral and sacroiliac syndromes with special emphasis on the areas of referred pain: the 5th lumbar and 1st sacral nerves for the lumbosacral joint; the 4th and 5th lumbar and 1st and 2nd sacral nerves for the sacroiliac joint. During this period numerous spinal and sacroiliac fusions were done for low back and sciatic pain; therapeutic failures were not uncommon. In retrospect it appears that one of the factors responsible for popular discredit of these operations was their application to so-called sacroiliac or lumbosacral strain. These diagnoses afforded a convenient method of circumventing normal roentgenologic and pathologic findings.

During the past ten years three new clinical entities have assumed a considerable degree of importance in the problem of low back pain and sciatica. Kocher in 1896 reported a case of traumatic rupture of an intervertebral disc. In 1911 Middleton and Teacher and Goldthwait described cases of cord compression due to changes in the intervertebral disc. During the decade from 1923 to 1933 extradural cartilaginous protrusions had become a not infrequent finding by neurosurgeons. They were described as "chondroma", "myxochondroma," "fibroma," and fibrochondroma," suggesting a neoplastic origin. However, Dandy in 1929 used the term, "loose cartilage from the interverbral disc," and Elsberg in 1931 reported a considerable series using the term, "ecchondrosis," to indicate their non-neoplastic nature. The work of Andrae and of Schmorl in 1929 indicated that posterior protrusion of the nucleus pulposus occurred in about 15% of adult subjects, but no clinical significance was implied. By 1930 the term "Schmorl's nodule" had been applied to these protrusions in the German literature. In 1933 Mixter and Barr in this country and Mauric in France associated these cartilagionus protrusions with the nucleus pulposus. Since 1933 numerous reports have appeared on results of operative removal of these lesions, culminating in a recent report covering "more than three hundred proved cases." The most common sites are the 4th and 5th lumbar interspaces.

The diagnosis is based on a history of low back pain preceded by trauma, followed after an interval by sciatica pain which is frequently increased by sneezing, coughing or straining. Periods of remission and exacerbation of symptoms are common. Paresthesias localized to the sciatic dermatones are of diagnostic importance. The significant objective findings are stiffness of the lumbar spine, flattening of the normal lumbar curve with a lateral list. Limitation of flexion of the spine and of straight leg raising are commonly present. Motor weakness, especially referrable to the peroneal or tibial nerves, may be demonstrable in advanced cases. Diminution or absence of the ankle jerk or occasionally the knee jerk together with hypesthesia of the 5th lumbar, 1st or 2nd sacral dermatones, constitute the most significant objective findings. Lumbar puncture may reveal elevation of total protein and occasionally evidence of spinal fluid block may be obtained. Final confirmation of the lesion usually rests on contrast roentgenologic studies of the spine by means of air or lipiodol.

Hypertrophy of the ligamentum flavum was mentioned by Elsberg in 1913 and 1916. Towne and Reichert reported this condition in 1931 and Spurling, Mayfield and Rogers in 1937. The subject was reviewed by Naffziger, Inman and Saunders in 1938 together with a consideration of intervertebral disc lesions. The lateral attachment of the ligamentum flavum to the articular eminence brings it into relation with the emerging spinal roots. Thickening of the ligament at this site is a potential source of root pressure. Measurements of the normal ligament in the lower lumbar region by Spurling, Mayfield and Rogers and by Horwitz showed a maximum thickness of 7 mm. Hypertrophy of the ligament has been most frequently reported in the 4th or 5th lumbar interspaces. The association of hypertrophy of this ligament with protrusion of the intervertebral disc was emphasized by Love in 155 of 175 cases with protruded disc. In only 12 cases did he find significant thickening of the ligament without associated disc involvement. The symptom chronology and physical signs of thickening of the ligamentum flavum are essentially the same as those of protrusion of the intervertebral disc.

In 1935 Ober reported a series of cases with low back and sciatic pain with evidence of contracture of the fascia lata, particularly the ilio-tibial band. Limitation of flexion of the spine and straight leg raising were present in these cases and there was restriction of gravity adduction of the extended thigh on the affected side (Ober's sign). Surgical division of the fascia lata at the level of the anterior superior iliac spine was carried out. In 1937 Ober, on the basis of 415 cases contributed by himself and other orthopedic surgeons, found complete relief in 75% of the patients.

Diagnosis of these three conditions should be based upon the results of a complete general, orthopedic and neurologic survey of the situation, including roentgenograms and study of the spinal fluid. The indiscriminate use of lipiodol may lead to exacerbation of symptoms, especially in inflammatory lesions. It should be restricted to cases where subsequent laminectomy is probable. There are no short cuts to diagnosis and myelography must be reserved as a corroborative rather than an absolute diagnostic procedure. In addition to technical artifacts, it is now apparent from the recent studies of Botts and of Horwitz that asymptomatic cartilaginous displacements are not infrequent. Horwitz found true herniation of the intervertebral disc in 6% and bulging of the 5th lumbar intervertebral disc in 28% without evidence of root compression.

To profit by the lessons learned from the earlier fusion procedures it is essential that major operations should be reserved for those cases of really intractable pain or progressive neurologic phenomena. In the milder cases conservative treatment and support are being emphasized in certain circles. Laminectomy with manipulation about the spinal roots is truly a neurosurgical procedure and should be undertaken under the same circumstances as removal of spinal cord neoplasms. It is too early to assess the final results of operative treatment in these conditions. Recurrence of symptoms are now receiving occasional mention in the literature and a conservative attitude is still indicated.

W. J. G.

* * * *

THE PREMARITAL EXAMINATION

Today there are nineteen states in the Union requiring premarital blood tests for syphilis. Of these nineteen only three require a physical examination of both partners and one state requires a physical examination of the male applicant only. Four other states require a certificate from the physician as to freedom from any venereal disease but the law does not specify what the physical examination shall include. Obviously, this latter type of legislation is out of date. A total of seventeen states and the District of Columbia have no requirements of any kind on syphilis and gonorrhea among those contemplating matrimony.

We in Connecticut congratulate ourselves on being among the first to pass a law requiring a standard blood test for syphilis and freedom from the communicable stage of the disease in both partners. We have only to turn toward the east, however, to find that in the adjoining State of Rhode Island more rigid requirements must be met. There the law applies not only to syphilis but also to tuberculosis and to gonorrhea. A physical examination is required as well as a standard laboratory test for syphilis and freedom from communicable infection. Turning to the north, matrimony may be entered upon in Massachusetts without thought for blood test or physical examination.

It is not impossible to conceive of the existence of the early case of syphilis with a negative blood test. Nothing will disclose this state of affairs but a physical examination which may be augumented when indicated as required in Tennessee, by a dark field examination. How ineffectual to require an examination of the male applicant and permit the female to marry without an examination, as is done in Wisconsin!

Our patients are gradually becoming educated to a complete physical examination before marriage. We should foster and encourage this trend. The marital happiness of many a couple might readily have been secured by proper measures instituted early and based on abnormalities discovered in a complete physical pre-marital examination. Sometimes it is only a bit of wise advice that is needed to relieve anxiety and to prevent conjugal difficulties, but this advice has very little weight unless founded on a knowledge of facts as disclosed by a physical examination. The intelligent citizen is gradually becoming educated to preventive medicine as applied to the individual and made more complete by the annual physical check-up. There is no better time to encourage this attitude than just prior to marriage when, instead of merely a blood test, both partners are entitled to a complete physical examination.

* * * *

THE NATIONAL PHYSICIANS COMMITTEE

Your Representative

The National Physicians Committee for the Extension of Medical Service must have your support if it is to accomplish its self imposed task. These objects for which the Committee has been formed are: 1. making possible the providing of medical service to the indigent and those in the low income groups and securing the most widespread distribution of the most effective methods and equipment in medicine and surgery; and 2. countering destructive propaganda by familiarizing the public with the facts in connection with the methods and the achievements of American Medicine.

The personnel of the Central Committee is expanding and bears witness to the growing stability of this Committee. It is just coming to be realized that it is strictly a physicians' institution; that it has undertaken a task of vast scope and vital importance to the medical profession and to the public. Great progress already has been made over a period of a few months but it will take active cooperation over many months continuously to enable it to achieve in proportion to the tremendous responsibility that has been assumed.

The Committee is supported entirely by voluntary contributions. Connecticut physicians have given generously but not all Connecticut physicians have given. Your local representatives on the Committee are Creighton Barker and Herbert Thoms in New Haven, Walter R. Steiner and the Editor of the Journal in Hartford

* * * *

HUGH CABOT, SALESMAN

No more outspoken and biased salesman of any of the recent plans for medical care has arisen than Hugh Cabot, M.D., who is now peddling group practice through his book "The Patient's Dilemma," and more recently through magazine articles. An example of the latter appeared in the April issue of American Magazine. Laurance Redway, Editor of the Westchester Medical Bulletin, advises his membership "to read carefully this artful piece of special pleading, and to note the 'rabbit-stew' character of the defamatory cartoon" accompanying the article.

Just why Doctor Cabot of late has stooped to such odd peregrinations of both legs and hands it is a little puzzling to determine but what is still more puzzling is why he does not tell the truth. Testimony in court under oath by a physician should never afford the slightest possibility of doubt as to its veracity. No more should the public be fed with such propaganda as this: "I feel that the most of the trouble with medicine today comes from this system of private practice." "It is this system which is keeping the patients home in droves while the doctors are wondering how to pay their rent." "I am appalled at the inadequate, inferior, and terribly expensive care that the American people are receiving today." "As usual, it's the great middle class which is suffering most." "With organized medicine fighting to protect the fee system, the situation is bound to get worse rather than better."

Doctor Hugh Cabot would have us plunge into group practice, divided responsibilities, buck passing, and all, because we are such an immoral group of individuals without principle or high standards! Boston still may be the home of the bean and the cod, but the Cabots no longer show evidence of talking only with God.

☆☆

CRIMINAL ABORTIONS IN FRANCE

According to the correspondent of the Journal of the American Medical Association, France is the only civilized country in which coffins are more numerous than cradles. Criminal abortion is undoubtedly one of the most important causes of this tragic situation. In 1905 Dole Doleris pointed out that in the maternity wards of Paris there were more cases of self-provoked abortion than of confinement cases. Physicians and sociologists for a long time have been stressing this national peril and calling for laws against criminal abortion. Criminal abortion is found at all social levels and is from five to six times more frequent among married women than among unmarried. In face of this serious situation, a law was decreed July 29, 1939, increasing the penalites against criminal abortion and intensifying action against physicians, midwives and others guilty of this practice.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

Annual Meeting of House of Delegates

The Annual Meeting of the House of Delegates will be held in the Hunt Memorial Building, 38 Prospect Street, Hartford, at 10:00 A.M. Tuesday, May 21st. The session will continue throughout the day. Members of the House will be the guests of the Society at luncheon at 1:00 P.M. The second meeting of the House of Delegates to act upon amendments to the By-Laws and unfinished business will be held at the Hotel Bond on Thursday morning, May 23, at 9:30 A.M. Elected delegates who are unable to attend the meeting of the House should arrange with the secretaries of their county associations for the attendance of an alternate.

* * * *

Amendments to the By-Laws

The Council will recommend to the House of Delegates at its Annual Meeting on May 21st, that the By-Laws of the Society be amended as follows:

Chapter II, Section 1, Paragraph 2. The annual tax shall be collected from all such members except the secretaries of County Medical Associations, but the taxes of any member may be remitted by vote of the House of Delegates upon recommendation of any County Medical Association.

To be amended by the deletion of the entire second paragraph, and to substitute therefor a new paragraph as follows:

Chapter II, Section 1, Paragraph 2. The annual tax shall be collected from all such members except the secretaries of the County Medical Associations. *Members who have been in good standing in the Society for forty consecutive years or who have attained the age of sixty eight and shall have been members of the Society for the fifteen years immediately preceding, shall upon written request addressed to the Treasurer of the Society, be exempted from the further payment of dues and will continue as active members of the Society enjoying all rights and privileges.* The tax of any member may be remitted by majority vote of the House of Delegates upon recommendation of any County Medical Association.

Chapter VI, Section 4. The Treasurer . . . . . . and he shall pay money out of the treasury only on a written order of the President, countersigned by the Secretary; . . . .

To be amended by the deletion of "countersigned by the Secretary" and the substitution of "countersigned by the Chairman of the Council," so that the section will read:

Chapter VI, Section 4. The Treasurer . . . . . . and he shall pay money out of the treasury only on a written order of the President, countersigned by the *Chairman of the Council*; . . . .

Chapter VII, Section 1. The Council shall consist of one Councilor from each county and the President, the President-Elect, the Secretary, the Treasurer, the Editor of the Journal, and the Legislative Secretary. It shall be the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

To be amended by the deletion of the "Legislative Secretary" and the addition of "Delegates to the American Medical Association" so that the section will read:

Section 1. The Council shall consist of one Councilor from each county and the President, the President-Elect, the Secretary, the Treasurer, the Editor of the Journal and the *Delegates to the American Medical Association.* It shall be the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

* * * *

Conference Committee with the State Board of Examination and Registration of Nurses

The President of the Society has appointed a committee consisting of Louis F. Middlebrook, Jr., Hartford; Robert J. Lynch, Bridgeport and Harry L. Berman, New Haven, to confer with the State Board of Examination and Registration of Nurses with respect to the interpretation and administration of the revised statute covering the licensing and registration of trained attendants.

* * * *

Conference Committee with the Connecticut Pharmaceutical Association

The Council has appointed a conference committee from the Society to meet with the similar committee from the Connecticut Pharmaceutical Association. This is a cooperative effort that has long been sought and the Secretary is pleased to announce its accomplishment. The Committee is Stanley B. Weld, Hartford, Chairman; Walter I. Russell, New Haven; John H. Foster, Waterbury; John C. White, New Britain; William M. Stahl, Danbury.

* * * *

Fairfield County Association Endorses Program of the National Physicians' Committee

The Board of Trustees of the Fairfield County Medical Association recommended and the Association adopted a resolution at its Annual Meeting on April 9th, to endorse the program of the National Physicians' Committee and recommended that a resolution to this effect be presented to the House of Delegates of the State Society at its Annual Meeting.

⁂

ARMY EXPERIENCE FOR PHYSICIANS

An interesting medical corollary to the augmentation of the United States Army during 1940 and 1941 and to the planned large scale Army maneuvers during the spring and summer of 1940 is the broad medico-military experience which a great number of civilian physicians will receive. Medical Reserve officers are being used to augment the entire Army Medical Service, which includes everything from small unit installations to large Station Hospitals, General Hospitals, and hospitals designed primarily for the treatment of specific types of cases.

Physicians under 35 years of age who are desirous of obtaining extended active duty with the Army but who do not hold Reserve commissions are being offered appointments in the Medical Corps Reserve in the grade of 1st Lieutenant, in order to permit them to be placed on such duty. Captains and Lieutenants are at present being offered excellent assignments throughout the continental United States, and it is hoped that authority will be granted to actually permit some officers to go to Hawaii and Panama. In addition to having a new and very busy experience in the practice of medicine, the average officer finds the pay and allowances attractive. The pay and allowances for a married 1st Lieutenant amount to approximately $263.00 a month; for a single 1st Lieutenant to approximately $225.00 a month; for a married Captain to approximately $316.00 a month; and for a single Captain to approximately $278.00 a month. In most cases the above pay and allowances would apply inasmuch as Government quarters are not usually available for officers on extended active duty. In the few instances where Government quarters are available, the amounts would be $40, $60, and $80 less per month respectively. In addition, the officer is reimbursed for mileage traveled from his home to his station, and upon completion of his tour of duty is reimbursed similarly for the travel to his home.

Application for one year of active duty, or for appointment in the Medical Corps Reserve with a view to obtaining one year of active duty with the Army, should be requested at once by a letter addressed to the Commanding General of the Corps Area where the physician permanently resides. In addition, the application should contain concise information regarding permanent address, temporary address, number of dependents, earliest date available for active duty, and that internship has been (or will be) completed; and it should be accompanied by a report of physical examination recorded on the Army Form W. D. A. G. O. 63, which may be obtained from any Army station. From the group of Reserve officers placed on extended active duty since August 1939, over 25% of those within the age requirements of 32 years of age or less for commission in the Regular Army Medical Corps found military service sufficiently to their liking to cause them to take entrance examinations for the Regular Army.

A. M. GRIFFIN
Vice-president

W. M. ALLEN
President

CAT.

H. T. NIVISON
Treasurer

O. H. BARTINE
Board of Trustees

W. B. SWEENEY
Secretary

A. W. BUCK
Board of Trustees

CAT.

OFFICERS

Connecticut Hospital Association

Connecticut Hospital Association

AN OUTSTANDING HOSPITAL ADMINISTRATOR TAKEN BY DEATH

Miss Mary Ellen McIntyre, for the past twelve years administrator of the Meriden Hospital, passed away on March 4.

Miss McIntyre was widely known among the members of the medical and nursing profession, and during the twelve years she was at the head of the Meriden Hospital had done much to improve the standards of that institution.

She was a member of the American College of Hospital Administrators, the American Hospital Association, the Connecticut State Hospital Association, and the New England Hospital Association. She has always taken an active part in the work of the State Hospital Association and her loss will be keenly felt by all of the members.

* * * *

INTERNE INSTRUCTION AT BRIDGEPORT HOSPITAL

One of the serious problems in any hospital is to give the interne the best possible opportunity to continue not only to perform his usual interne duties, but to substitute laboratories for lecture rooms — that is, to replace theoretical teaching with practical experience, thus giving our internes a practical education which helps them to become more capable practitioners.

In a teaching institution, it is possible for the interne to continue his instruction to a greater degree than in a non-teaching institution. With this in mind, the Bridgeport Hospital instituted a plan, a number of years ago, of inviting the internes to actively participate in its Staff meetings. Two years ago, under the direction of the Interne Committee, it began a course of lectures which have been mainly medical and surgical, although each of the specialties has given also two or more hours. Lectures in jurisprudence were also instituted. The Bridgeport Hospital is keenly interested in its internes, and likes to feel that the year of internship is a continuation of the school years. At the end of the present year, its lectures will have numbered some eighty odd hours. Excellent cooperation from the staff and internes has been received and they have appreciated the kind of service given to them.

The Interne Committee developed a plan whereby all of the internes attend the lectures in a body and the ex-internes are called upon to substitute during that period. In only a few instances have real emergencies arisen when it has been necessary to call upon an interne to leave the lecture.

The Staff are most co-operative in presenting their lectures and are providing the instruction to the internes with real enthusiasm. The Administrative Department is also giving all possible encouragement to this course of instruction.

* * * *

MINUTES OF MEETING

March 29, 1940

The Board of Trustees of the Connecticut Hospital Association met at the Hartford Hospital at 2:00 P.M., Doctor Wilmar Allen, President, presiding.

Members present:		
	Doctor Allen	Doctor Buck
	Miss Griffin	Mr. Bartine
	Miss Nivison	Mr. Sweeney
Absent:	Mr. Davidson	

The minutes of the previous meeting were approved.

Doctor Allen outlined suggestions for the program for the coming convention May 22 at the Hotel Bond, Hartford, suggesting that the convention open with a luncheon at noon. The program would follow at 2:00 P.M. with two speakers leading the discussion on the general subject of Automobile Insurance and Highway Problems.

Doctor Allen stated that the State Medical Society had extended an invitation to the members to attend the evening dinner of the State Medical Society following the Convention. Discussion ensued.

VOTED: To authorize the president to extend an invitation to Commissioner John C. Blackhall of the State Insurance Department and also to Commissioner Michael Connor of the Motor Vehicle Department to lead the discussion at the Convention.

The Secretary was authorized to arrange with the Hotel authorities for the luncheon meeting and to mail notices to the members by May 1.

The secretary read a note of thanks from the family of the late Miss Ellen McIntyre, Superintendent of Meriden Hospital.

The president announced the appointment of Miss Ann Griffin, Superintendent of Danbury Hospital, to fill the vacancy on the Advisory Committee of the State Board of Nurses' Examiners.

The secretary was requested to notify Chairman Hamilton of the Resolutions Committee to draw up suitable resolutions for presentation at the next annual meeting on the death of Miss McIntyre.

Mr. Fox of the Fox Press, Inc., Hartford, submitted specimen pages and quotations upon request for the proposed Hospital Handbook on Statutes Pertaining to Hospitals. Price submitted is $3.80 per page on the basis of 100 copies. This includes typing, printing, gathering, punching and inserting sheets in binder. The binders were quoted at 75 cents each in quantities of 100. Die stamping in gold ink on cover for a 3-line set-up 25 cents each additional. Mr. Fox agreed to furnish 40 additional sets without the binder to be included without additional charge. The Board gave considerable time to discussing the style and type of binder, and the matter was left to the President and Secretary with power. Mr. Fox agreed to present a more approximate estimate of the number of sets and cost early in the coming week and requested one month's time for printing.

Miss Nivison, Treasurer, reported the following budget for the year which was accepted and placed on file.

CONNECTICUT HOSPITAL ASSOCIATION
1940 BUDGET

Estimated Income	
Dues — 34 hospitals	$1717.30
Dues — Assoc. Institutional Member	25.00
Dues — 44 Personal Members	342.00
Interest on Bonds	30.00
Dues — Personal 1939	24.00
Dues — Institutional 1939	25.00
	$2163.30
Estimated Expenditures	
Institutional dues to A. H. A.	
34 Hospitals — 1 Assoc.	$1149.14
Personal Dues to A. H. A. — 44 members	142.00
Personal Dues to N. E. H. H. A. — 44 members	66.00
Telephone, stationery, stamps	100.00
Secretary	50.00
Printing, programs, etc.	50.00
Traveling Expenses	100.00
Connecticut State Medical Journal	700.00
Miscellaneous	20.00
Auditor	20.00
	$2397.14

Balance from 1939 —	$574.19
Deficit — 1940	233.84
Balance	$340.35

The Secretary was authorized to purchase the necessary stationery and envelopes for the year and to secure stenographic assistance when necessary including a detailed report on the annual meetings.

The Board discussed at considerable length the desirability of securing legal assistance on an annual basis and the preparation of a program for legislation. It was agreed to include this item in the agenda for the May meeting.

Mr. Richard Hancock, Director of the Lawrence and Memorial Hospital, New London, Connecticut, was selected as State Chairman of the National Hospital Day Program for 1940.

Miss Nivison, Treasurer, gave a detailed report concerning the status of members submitted from the National Association and not on the list of the State Association. Secretary read several communications including one from the Secretary of the New England Hospital Assembly relative to the same subject, and the matter of memberships was tabled pending the May meeting.

At that time it was considered desirable to discuss also the status of admission into the State Association of State Institutions.

Following members were elected to the Committee on Government Relations for the coming year:

Mr. Oliver Bartine, Chairman
Miss Anna Griffin
Mr. William B. Sweeney
Mr. Sydney Davidson
Mr. Harry Kennedy
Mr. Robert Brough
Dr. Wilmar Allen
Miss Helen Nivison
Dr. Albert Buck
Mr. Allen Brosmith
Mr. James Hamilton
Mr. Shepherd B. Palmer

The Secretary read a communication from the Commission on Prevention and Care of Sickness, Doctor Creighton Barker, Chairman, outlining the study and procedure and asking for advice and counsel on matters pertaining to our organization. Inasmuch as our president is a member of this commission, the Board anthorized Doctor Allen to present policies of the Hospital Association to the Commission.

VOTED: To adjourn at 5:18 P.M.

(Signed) William B. Sweeney, *Sec.*

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

HEALTH INSURANCE COMES TO THE FORE

Bertram M. Bernheim, M.D., Johns Hopkins Hospital, Editor of "Medicine at the Crossroads," would consign Hippocrates to the Metropolitan Museum if necessary.

* * * *

The American Federation of Labor is not in favor of a payroll deduction for health insurance but believes that this should be a Federal government project.

* * * *

Robert J. Watt, International Labor Representative, says there are too many plans for health insurance and that such a program is not wise until the people know what they want. He believes the modern health insurance bill as introduced in the New York Legislature to be over complex and favors rather a cash indemnity for the sick workman.

* * * *

Michael M. Davis, Chairman of the Committee on Research in Medical Economics believes the cash indemnity plans for medical care, now operating under the laws of New York State, are too narrow and too costly for what is offered. The same Mr. Davis would like to see a group of physicians place the present bill for health insurance on the operating table and study it in respect to medical care from all angles.

* * * *

Arthur J. Altmeyer, Chairman of the Social Security Board, can see no reason why a plan for health insurance cannot be devised which will in no way enroach upon the free choice of physicians or the intimate relationship between physician and patient.

* * * *

The Editor of the New York State Journal of Medicine believes the present rush for compulsory health insurance entirely out of order until voluntary indemnity plans have had a chance to prove their worth. It sounds to him like a game to batten a lot of political hangers-on at the public expense and is not a spontaneous popular response to a pressing need. Superintendent Pink of the New York State Insurance Department is quoted as stating that non-profit hospital service and medical indemnity corporations are worthy of experimentation before resorting to compulsory health insurance or state medicine.

☆☆

ADVANTAGES OF STATE MEDICINE

The following advantages of State Medicine are offered in an article by W. G. Bishop, M.D., appearing in the January issue of the Journal of The South Carolina Medical Association:

(1) State Medicine would aid in preventing disease as its places the emphasis on preventive medicine;

(2) State Medicine would prevent much human suffering by preventing bankruptcy and poverty due to long spells of sickness in low income families;

(3) State Medicine would eliminate great waste in medical service such as found in the use of patent medicines, the employment of faith healers and other groups of faddists, the practice of fee splitting and its inevitable consequence unnecessary operations, and the high costs of present private practice due to expense of overhead;

(4) State Medicine would benefit the great majority of practicing physicians by tending to balance the work better among physicians;

(5) State Medicine would promote good citizenship by improving the health of the people and thus in turn improving efficiency and promoting happiness.

(Would it? I wonder. — Ed.)

☆☆

Acute pleurisy with effusion should be considered as a case of potential tuberculosis unless some other cause for the condition is found. Observation should be continued for at least five years after the cessation of the actual pleural disease if the needlessly high mortality from pulmonary tuberculosis following sero-fibrinous pleurisy is to be avoided. From a public health standpoint the cases should receive the same repeated observations as a case of frank pulmonary tuberculosis.

Schneider, L., British Jour. Tuber., April, 1939.

-The- General Practitioner's Forum

An important and often overlooked detail in the management of diabetes mellitus is the care of the feet. As the incidence of infection is high and the consequences potentially serious, diabetics should be thoroughly instructed in proper foot care. The following is an outline of the routine used in a large orthopedic clinic:

1. Soak the feet in warm soapy water for ten minutes every day.
2. Dry thoroughly, especially between the toes.
3. Massage with rubbing alcohol.
4. Massage the soles and heels with lanolin. This softens the calluses.
5. Wear well fitted shoes and change socks daily.

If the feet have a tendency to coldness, the following exercises are recommended:

1. Sit on the edge of the bed, point the toes upward and downward. Repeat each twelve times.
2. Make a complete circle of the foot twelve times.
3. Lie on the bed and raise the legs to an angle of 45 degrees. Pillows or an overturned chair may be used for support. Hold this position for three minutes.
4. Hang the legs over the edge of the bed for three minutes. Repeat each maneuver six times. If the feet still tend to be cold, do these exercises morning and night.

The inconvenience to the patient is amply justified in the results obtained.

* * * *

Finestone is working with the theory that different strains of infectious organisms react independently to the sulfonamide group of drugs. Clinical experience has already shown that all strains of pneumococci are not affected by sulfapyridine, and that the same relationship exists with sulfanilamide and the streptococci. Taking this as a basis, Finestone cultures out the offending organism and tests it in vitro against various dilutions of the sulfonamides. From the one which shows the greatest activity, he estimates a proper dosage. Clinical evidence of the soundness of this theory is mounting.

* * * *

This is the open season for poison ivy and poison oak dermatitis. No standard of treatment, whether with local applications or with the specific extracts in oil, fits all cases. A treatment which has had five years of boys summer experience to prove its worth is presented here. Early cases: Wash all points of contact with ether giving special attention to the fingers and nails. Follow this with a thorough washing with soap and water. All clothing worn at the time of contact is washed or cleansed before being used again.

Later cases with blisters: Areas are soaked in a 20% solution of sodium thio-sulfate— ordinary photographers hypo solution. Blisters are opened. The solution is allowed to dry on the areas. This procedure is repeated as often as necessary.

No late severe cases were seen at the camp. In private practice, these were treated with tubbings in the solution. Relief of the symptoms was prompt.

* * * *

The old family doctor gets a pat on the back from Summers, Kansas City pediatrician. In Nov. 1939 issue of the J. Missouri M.A., he stresses the old doctors "watchful waiting" as the sensible thing to do in 99% of all children's acute illnesses. In the other 1% where specific therapy is available, speed is essential, and all efforts must be directed to the accurate recognition of these conditions.

* * * *

Hanelin in the J. Mich. State Med. Soc., reports the use of inhalations of benzedrine sulfate for the relief of paroxysmal hiccough. Since it appeared twelve more case reports were studied. The relief is prompt and complete.

Annual Reports

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1939 - 1940

REPORT OF THE TREASURER

To the House of Delegates:

Gentlemen:

It is again my privilege to report on the finances of the Connecticut State Medical Society for the calendar year 1939. The accounts of the Treasurer, of the Secretary, of the Journal and of the Clinical Congress have been examined by the Certified Public Accountants, Hadfield, Rothwell, Soule & Coates of Hartford, Connecticut, whose report is at the office of the State Society subject to inspection by any member. A synopsis of their report is given herewith.

Some of the suggestions of the accountant made in my report one year ago have been carried into effect, others are being carried into effect during the current year. The custodianship of the funds of the Clinical Congress was provided for by the House of Delegates last year by special by-law. Those funds are not under the direct control of the Treasurer but are subject to his annual audit and report is given herewith.

Seward and Monde, Certified Public Accountants of New Haven, Connecticut, have been engaged to supervise the fiscal affairs of the Society for the year 1940. On their advice and with their assistance unnecessary bank accounts have been eliminated and no cash, with the exception of two revolving funds, is now being withdrawn except upon authorization of the Treasurer. Two revolving fund accounts are placed at the disposal of the Executive Secretary and of the Journal management for operating purposes. These allowances of $2000.00 in each case have been authorized by the Council and will not be increased unless experience indicates otherwise. Expenditures for these funds will be verified by the Treasurer, or his staff, before replenishing the funds each month.

The bookkeeping work is now centralized by means of complete monthly reports of all activities with the exception of those of the Clinical Congress. It will therefore be possible in the future to prepare a statement at the end of each month setting forth the complete financial status of the Society. This bookkeeping will show not only cash balances but also will show bills payable (liabilities) and accounts receivable (assets), items which are especially significant for the Journal.

Respectfully submitted,
JAMES RAGLAN MILLER

General Fund Resources and Liabilities as of December 31, 1939

RESOURCES

Current Resources:			
Cash on Deposit:			
Under control of treasurer:			
Union & New Haven Trust Company, New Haven		$ 7,238.69	
Capitol National Bank & Trust Company, Hartford		1,925.72	
Gurdon W. Russell Fund:			
Mechanics Savings Bank, Hartford		1,329.78	
			$10,494.19
Not under control of treasurer:			
Executive Secretary's account:			
Second National Bank, New Haven		192.03	
Scientific Secretary, Journal account:			
Capitol National Bank & Trust Company, Hartford		3,360.18	
Clinical Congress accounts:			
New Haven Bank, N.B.A., New Haven	$ 763.53		
New Haven Savings Bank, New Haven	3,132.74	3,896.27	
1940 Commercial Exhibit account:			
Second National Bank, New Haven		534.74	7,983.22
Total Cash on Deposit			18,477.41
Dues Receivable—1939			11.40
Inventory of automobile emblems			102.00

RESOURSES (Cont.)

Other Resources:			
Gurdon W. Russell Fund:			
$8,000. par value of bonds, stated at market values December 31, 1937			6,400.00
(Market values December 31, 1939 $6,185.00)			
Total Resources			$24,990.81

LIABILITIES

Current Liability:			
1939 dues collected in error, to be refunded			$ 3.80
General Fund Surplus:			
Under control of treasurer:			
Represented by uncollected dues, auto emblems and Russell Fund	$6,513.40		
Cash surplus—represented by excess of cash on deposit under control of treasurer over current liability	10,490.39		
Total	$17,003.79		
Cash surplus not under control of treasurer:			
Executive Secretary	$ 192.03		
Scientific Secretary	3,360.18		
Clinical Congress	3,896.27		
1940 Commercial Exhibit	534.74	7,983.22	
Total General Fund Surplus			$24,987.01
Total Liabilities			$24,990.81

O. C. Smith Trust Fund as of December 31, 1939

	Assets	Liabilities
Cash on Deposit:		
Mechanics Savings Bank, Hartford—Account #55673	$1,000.00	
Mechanics Saving Bank, Hartford — Account #134553	464.84	
Reserve for O. C. Smith Trust Fund		$ 1,464.84
Totals	$1,464.84	$ 1,464.84

APPROPRIATIONS AND EXPENDITURES CHARGED THERETO AND UNEXPENDED BALANCES FOR THE CALENDAR YEAR 1939

Description	Appropriations in Force December 31, 1938	Appropriations Voted at Council Meeting April 5, 1939	Transfers Authorized by Council		Total	Expenditures — Total Disbursed by Treasurer	Returned or Returnable By Secretaries	Unexpended Balances Transferred to Surplus, December 31, 1939
			Additions	Deductions				
	$	$ (a)	$	$	$	$	$	$
Treasurer's:								
Annual meeting	536.51	—	—	536.03	—	—	—	--
Chairman of Council	150.00	150.00	—	—	300.00	300.00	—	—
Delegates to A.M.A. convention	230.87	—	19.95	—	250.82	250.82	—	—
Legislative Committee	1,129.75	300.00	—	513.34	916.41	561.80	—	354.61
Legislative Secretary	500.00	—	—	250.00	250.00	—	—	250.00
Miscellaneous	—	500.00	836.03	19.95	1,316.08	1,252.59	153.86	217.35
1938 Tumor Committee	100.00	150.00	—	—	250.00	—	—	250.00
1938 Council Meetings	48.20	75.00	—	—	123.20	70.63	—	52.57
Executive Secretary	2,850.00	3,440.00	—	—	6,290.00	6,290.00(b)	233.36	233.36
Scientific Secretary	1,936.66	2,400.00	463.34	—	4,800.00	4,800.00(b)	2;209.68	2,209.68
Totals	$7,481.51	$7,015.00	$1,319.32	$1,319.32	$14,496.51	$13,525.84	$2,596.90	$3,567.57

(a) For six month period beginning July 31, 1939 to and including December 31, 1939.

(b) Allocation of specific expenditures to the above amount not obtainable in the manner the records are maintained, owing to the collection and expenditures of receipts by the secretaries.

Cash Receipts and Disbursements for the Calendar Year 1939

General Fund

Cash on Deposit December 31, 1938:			
Union & New Haven Trust Company, New Haven			$ 8,421.91
Receipts:			
1938 dues (delinquent)		47.50	
1939 dues		13,003.60	
Journal–balance payment on loan		734.11	
Auto emblems		210.00	
Appropriation refunds		195.19	
Annual meeting surplus		315.36	
Interest on savings account		18.02	
Overcollection of dues		29.60	
Total Receipts		$14,553.38	
Disbursements:			
Appropriations:			
Chairman of Council		300.00	
Delegates A.M.A. convention		250.82	
Legislative Committee		561.80	
Miscellaneous:			
Bond for treasurer	12.50		
Insurance	9.60		
Auditing services	610.30		
Directory expenses	194.30		
Other expenses	425.89		
		$ 1,252.59	
1938 Council meetings		70.63	
Executive Secretary		6,290.00	
Scientific Secfetary		4,800.00	
Printing applicable to 1939 annual meeting		59.24	
Auto emblems		200.00	
Overcollection of dues refunded		25.80	
Total Disbursements		$13,810.88	
Excess of Receipts Over Disbursements			742.50
Cash on Deposit December 31, 1939:			
Union & New Haven Trust Company, New Haven		7,238.69	
Capital National Bank & Trust Company, Hartford		1,925.72	$ 9.164.41

Gurdon W. Russell Account

Cash on Deposit December 31, 1938

Mechanics Savings Bank, Hartford		$ 1,602.98
Receipts:		
Interest:		
On bonds (a)	246.25	
On savings account	29.50	
Total Receipts	$275.75	$ 1,602.98
Disbursements:		
Permanent improvements to State Medical Society quarters #258 Church Street, New Haven	224.08	
New addressograph machine for Journal office, #54 Church Street Hartford	324.87	
Total Disbursements	548.95	
Excess of Disbursements Over Receipts		273.20
Cash on Deposit December 31, 1939:		
Mechanics Savings Bank, Hartford		$ 1,329.78

(a) August 1, 1939 interest coupon of $21.25 on $1,000. Boston and Albany Railroad Company, 4¼% improvement bond, not detached for collection until February 1940.

O. C. Smith Trust Fund

Cash on Deposit December 31, 1938:		
Mechanics Savings Bank, Hartford (principal)	$1,000.00	
Mechanics Savings Bank, Hartford (income)	480.89	1,480.89
Receipts:		
Interest on savings accounts		37.15
Total		1,518.04
Disbursements:		
Dues paid for deserving members		53.20
Cash on Deposit December 31, 1939:		
Mechanics Savings Bank, Hartford (principal)	1,000.00	
Mechanics Savings Bank, Hartford (income)	464.84	$ 1,464.84

Report of Executive Secretary

Cash Receipts and Disbursements for the Calendar Year 1939

Cash on Deposit December 31, 1938:		
The Second National Bank, New Haven		148.26
Receipts:		
Appropriation — State Society Treasurer	$6,290.00	
Refunds — clerical work	58.65	
Insurance refund	1.40	
Telephone commission	30.90	
Telegrams, refund	2.56	
Transfer and exchange, per contra	219.40	
Total Receipts	$6,602.91	

Report of Executive Secretary (Cont.)

Disbursements:		
Salary of Secretary	$1,500.00	
Stenographers	2,656.75	
Rent, light and telephone	1,274.76	
Office expense	482.51	
Miscellaneous	384.39	
Transfer and exchange, per contra	219.40	
Total Disbursements	6,517.81	
Excess of Receipts over Disbursements		85.10
Cash on Deposit December 31, 1939:		
The Second National Bank, New Haven	192.03(a)	
Remitted to Treasurer—July 1, 1939:		
Appropriation refund	41.33	$233.36

(a) Remitted to Treasurer — January 2, 1940 Appropriation refund

Report of Treasurer of the Clinical Congress

Cash Receipts and Disbursements for the Calendar Year 1939

Cash on Deposit December 31, 1938:		
New Haven Bank, N.B.A., New Haven	525.18	
New Haven Savings Bank, New Haven	$3,063.26	$ 3,588.44
Receipts:		
Registration fees	1,265.00	
Interest on savings account	69.48	
Total Receipts	$1,334.48	
Disbursements:		
Printing	412.16	
Clerical	63.40	
Speakers' expenses	226.55	
Dinners—committee	59.66	
Miscellaneous	258.88	
Registration fees returned	6.00	
Total Disbursements	$1,026.65	
Excess of Receipts Over Disbursements		307.83
Cash on Deposit December 31, 1939:		
New Haven Bank, N.B.A., New Haven	763.53	
New Haven Savings Bank, New Haven	$3,132.74	$3,896.27

Report of Scientific Secretary

Cash Receipts and Disbursements for the Calendar Year 1939

Cash on Deposit December 31, 1938:		
Capitol National Bank & Trust Company, Hartford		$ 1,150.50
Receipts:		
Appropriation — State Society Treasurer	$4,800.00	
Advertising	7,866.82	
Subscriptions	116.00	
Reprints	1,003.11	
Single copy sales	28.50	
Electrotype sales	214.03	
State Society Treasurer—from Russell Fund for purchase of equipment	324.87	
Total Receipts	$14,353.33	
Disbursements:		
Printing	$7,074.34	
Postage	227.25	
Stationery and supplies	31.00	
Telephone	63.83	
Salaries	2,695.00	
Rent	240.00	
Balance payment to Treasurer prior year loan	734.11	
Refunds of advertising receipts	46.00	
Electrotypes	328.59	
Editorial board expenses	86.59	
Traveling	68.55	
Furniture and equipment:		
Addressograph — cash provided from Russell Fund	324.87	
Furniture for office, #54 Church Street, Hartford	101.00	
Miscellaneous	122.52	
Total Disbursements	$12,143.65	
Excess of Receipts over Disbursements		$ 2,209.68
Cash on Deposit December 31, 1939:		
Capitol National Bank & Trust Company, Hartford		$3,360.18

Commercial Exhibit and Annual Meeting,

Cash Receipts and Disbursements for the Calendar Year 1939

1939 Commercial Exhibit and Annual Meeting

Cash on Deposit December 31, 1938:		
The Second National Bank, New Haven		243.63
Receipts:		
Commercial Exhibit 1939		2,445.00
Total		2,688.63
Disbursements:		
Commercial Exhibit expenses 1939	$1,415.03	
Annual meeting expenses	908.24	
Exhibitor's fee returned, contract cancelled	50.00	
Remitted to Treasurer, State Medical Society	315.36	
Tota. Disbursements		$ 2,688.63
Cash on Deposit December 31, 1939		None

1940 Commercial Exhibit and Annual Meeting

Receipts:	
Commercial Exhibit 1940	$587.50
Disbursements:	
Commercial Exhibit expenses	52.76
Cash on Deposit December 31, 1939:	
The Second National Bank, New Haven	$534.74

* * * *

REPORT OF COMMITTEE ON MEDICAL EXAMINATION AND MEDICAL EDUCATION

Mr. President and Gentlemen of the House of Delegates:

It was stated at Chicago that the 1940 meeting of the Council on Medical Education and Hospitals was one of the largest ever held. The papers in general were excellent and covered a wide field and were freely discussed.

Probably the most popular speaker was Dr. C. S. Boucher, Chancellor University of Nebraska, a non medical man. In his evaluation of graduate and professional schools, he placed medicine at the top and was very specific in his criticism of other professional schools. He strongly urged that medicine make its own specialists and govern and regulate this situation. Dr. Ray Lyman Wilbur in his address reported that in 1939 there were thirty-eight graduate schools.

The question of universal reciprocity was recommended and discussed. One finds it difficult to believe that this will ever prevail because of the different problems in the different states. However it seems possible to coordinate many of the activities of the various medical schools and examining boards.

The important question brought before the congress was of course the refugee question. Dr. Joseph Pratt reported that all but four states required citizenship for licensure and named these states: Maryland, New York, Massachusetts and Connecticut. Some of the representatives from other sections of the country were extremely critical of the refugees and insisted that citizenship was not too great a requirement for these applicants. It is doubtful if this group will ever be permitted to enter many of the states. On the other hand those speaking for the refugee were pleading for tolerance and fairness in handling this situation. Connecticut's stand in the matter seems to me an admirable one: requiring first papers of naturalization and considering the refugee solely on merit without favoritism or discrimination.

Connecticut should continue its membership in the Federation of Medical Examining Boards and should also be represented at the annual meetings.

Respectfully submitted,
T. P. MURDOCK
Secretary, Medical Examining Board

* * * *

REPORT OF EDITORIAL BOARD OF THE JOURNAL FOR THE YEAR 1939-1940

Quarterly meetings of the Editorial Board have been held in Hartford and New Haven during the past year. To these meetings have been invited the news editors from the various counties and at each meeting there have been at least two of these present. The year has been marked by an effort to improve the quality as well as the scope of the material contained within the Journal.

Papers presented at the Annual Meeting of the Society and at the Clinical Congress have been printed in so far as it has been possible to secure manuscripts from the speakers. A few of the papers of special value and interest presented before local Medical Societies have also been published. In addition there has appeared an increasing number of original papers from members of the Society and a few from physicians outside the State.

The advertising has continued in about the same amount as during the previous year, except for a slight decrease in local copy. With the increasing duties of the editor it has been impossible for him to personally canvas advertising prospects throughout the State as in previous years. A special agent on a commission basis has been placed in the field to secure advertising for the Convention (May) Issue this year. If successful, as he bids fair to be, he will probably continue in this role throughout the year. The majority of the national advertising is secured through the Cooperative Medical Advertising Bureau at Chicago, a subsidiary of the American Medical Association. To this Bureau we are greatly indebted for valuable assistance.

Because of the increasing amount of material submitted for publication it is becoming necessary to prune more carefully and refuse more frequently. All the papers presented before the Annual Meeting and the Clinical Congress will not appear in print hereafter because their contents do not always lend themselves to publication and they will be of little interest to our readers. In their place we are arranging for papers on special topics of interest by authorities in these fields. In addition it is planned to offer a series of historical articles preparatory to our sesquicentennial celebration in 1942.

The Connecticut Hospital Association now shares the Journal with the State Medical Society, is represented on the Editorial Board and recognies the Journal as its official publication. We are certain this is a step toward achieving the results we all desire for our patients.

Respectively submitted,

STANLEY B. WELD
Editor

* * * *

REPORT OF THE COMMITTEE ON THE CLINICAL CONGRESS FOR THE YEAR 1939

The Fifteenth Clinical Congress of The Connecticut State Medical Society was held at New Haven on September 19, 20, and 21, 1939. The program included nine lectures and fourteen five-minute talks during the forenoon sessions; seven symposia and five three-day courses during the afternoon sessions. Sectional meetings were held during the evenings. The facilities of the Sterling Law Buildings were made available by Yale University for the morning sessions. The afternoon sessions were held in the buildings of the Yale University School of Medicine and the New Haven Hospital.

The total registration was 581, of which number 544 were paid for at $2.00 each, and 37 were free admissions given to students and internes. The total number was 17 less than last year and 113 less than the registration for the Congress in 1937. Comparative registration figures for the five-year period since 1935 are as follows:

Clinical Congress	*Year*	*Number of Registrants*
11th	1935	627
12th	1936	633
13th	1937	694
14th	1938	598
15th	1939	581

This decreasing attendance at the Clinical Congress is a matter of great concern to your Committee. Although the cause is not entirely clear, criticisms have indicated that the program of the past year was not sufficiently attractive. Furthermore, the publicity may not have been adequate. The Committee will attempt to meet both of these criticisms in making plans for the Congress of 1940.

It is estimated that only about 25 per cent of the total number of the active practicing physicians registered in Connecticut attend the Clinical Congress. Of the total numner of the Connecticut State Medical Society, 24.6 per cent registered for the Congress. On the other hand, 429 members of the Connecticut State Medical Society registered for the last Congress, comprising 73.8 per cent of the total registration.

The record of attendance at the 15th Clinical Congress according to counties, in comparison with the total registration, was as follows:

	Number	Percentage of Registrants	Percentage of membership in respective Societies
Total registration	581		
From Connecticut	515	88.6	
From Fairfield County	84	14.5	17.9
From Hartford County	96	16.5	15.6
From Litchfield County	17	2.9	21.1
From Middlesex County	21	3.6	27.1
From New Haven County	254	43.7	40.8
From New London County	31	5.3	21.6
From Tolland County	4	0.7	13.0
From Windham County	8	1.4	20.5
From outside of State	66	11.4	
From Massachusetts	22	3.8	
From New York	21	3.6	
From Rhode Island	9	1.5	
From New Jersey	5	0.9	
From Maine	5	0.9	
From New Hampshire	2	0.35	
From Florida	2	0.35	

The report of the Treasurer, Dr. Charles E. Sanford, is as follows:

Receipts:	
From registration fees	$1,265.00
Interest on deposits in bank	69.48
Total receipts	$1,334.48
Disbursements:	
Printing	$412.16
Clerical Work	63.40
Dinners (Committee)	59.66
Speakers' expenses	226.55
Miscellaneous	258.88
Fees returned	6.00
Total disbursements	$1,026.65

The surplus of receipts over expenditures amounted to $307.83.

The total assest of the Clinical Congress, in the form of bank deposits, amounted to $3896.27, as of December 31, 1939.

As in the past year, the Committee and the Congress itself were greatly aided by Dr. Creighton Barker, both as a member of the Committee and by the service rendered by the secretarial office of the State Medical Society under his direction. To the Journal of the Connecticut State Medical Society and to its editor, Dr. Stanley B. Weld, the Committee is indebted for the publication of advance notices, programs, and informative articles. The Chairman is grateful to all the members of the Committee for their unsparing efforts for the benefit of the Congress.

The Clinical Congress continues to attract the attention of organizations interested in the activities of a state medical society to provide a brief period of postgraduate education for physicians in practice. It has served as a model and has stimulated other groups, among whom are some of our neighbors, to institute medical assemblies for educational purposes. It is hoped that the Congress will be able to serve the physicians of Connecticut with increasing effectiveness and bring added distinction to the Society.

Respectfully submitted,
S. BAYNE-JONES,
Chairman

* * * *

REPORT OF THE LEGISLATIVE COMMITTEE FOR THE YEAR 1939-1940

The year 1940 is not a legislative year in the State of Connecticut and for that reason the activities of your Legislative Committee are largely those of planning. However, since the General Assembly of 1939 did not adjourn until after the Society's Annual Meeting, certain things that could only be tentatively spoken of in May 1939 may now finally be reported.

1. The Enabling Act for Hospital Service Corporations in which the Society was interested and helped to draft became a law.

2. A similar Enabling Act for Medical Service Corporations which was presented to the General Assembly by your Secretary with the idea that the future held a probability of the development of such projects and in the belief that it was desirable to have a statute regulating them, was also favorably acted upon and became a law. The wisdom of this step has been amply proven by the experience in other states who find their progress in this field blocked by the absence of appropriate legislation.

3. The bill to create a commission to study medical care in the State of Connecticut was enacted and some of the progress of the Commission appointed under that law is already known to you. Its activities are far from complete.

4. The legislation presented by the osteopaths which would permit the Osteopathic Board to give examinations and licenses to practice medicine and surgery was revised several times and supported with vigor by its proponents. In its final form it would have extended to the Osteopathic Board the right to give examinations in surgery and license successful candidates to practice surgery within the State. Many members of the Society aided your Secretary in opposing this legislation and the session closed without the bill being reported out of committee.

A companion bill to this that would have allowed any licensed physician to practice in any hospital receiving State aid was also defeated. Had this bill been passed it would have opened every hospital in the State to any physician, removing from the Board of Directors of such a hospital the right to select physicians who might practice within it. It also had another effect that was well hidden for there are a few osteopathic physicians who have been licensed to practice medicine and surgery by the Medical Examining Board, and it appeared quite clear that such licenses would have had the right to practice within the hospitals given to them. Moreover, had the bill amending the Osteopathic Act prevailed, an additional number of osteopaths would have been so privileged.

It is probable that your interest in what has been accomplished is less than your concern with what lies ahead. From this distance it appears that we will again be confronted with an attempt to liberalize the Osteopathic Practice Law to admit osteopaths to extended privileges. This is a campaign that is being steadily pursued throughout the country. In a few states results satisfactory to the osteopaths have been accomplished, in others, and Connecticut may fall in this category, there is a lull which undoubtedly prefaces another attack. It is generally conceded that this attempt to enlarge the field of osteopathic practice is motivated by the schools of osteopathy that are aggressively seeking new fields and opportunities for their graduates. These schools are without exception proprietary enterprises maintained for profit and that profit depends upon their attractiveness to students, so it is clearly to the advantage of the proprietors of these schools to offer bigger and better opportunities to their graduates. That we will be recurrently faced with this demand on the part of the osteopaths can hardly be denied and it is important that our interests and influences to combat it are well organized. To that end the Society has, as you know, appointed a special committee to inquire into the subject and make recommendations for the policy of the Society in the future. That committee will report later.

The second and more constructive objective of the Society is the amending and bringing up to date of the Medical Practice Law. A revision of that law is now under consideration by The Connecticut State Medical Examining Board and your Legislative Committee.

Your Secretary wishes to express his gratitude for the assistance rendered by the members of the Committee on Public Policy and Legislation and others in furthering the aims of the Society in its legislative program, and urges increased and extended interest in legislative affairs by all of our members.

CREIGHTON BARKER,
Chairman

* * * *

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

Mr. President, Members of the House of Delegates:

In its report of 1939 this Committee discussed and pointed out the defects of the late, but not lamented, Wagner Bill (S. 1620) which died a painless death, presumably from pecuniary inanition, at the end of the 1939 session of Congress.

In that report it was pointed out that, among other things, the bill sponsored the erection and equipment of a considerable number of hospitals, health centers and diagnostic laboratories at government expense. Your Committee suggested that the health centers and diagnostic machinery could well be combined with strategically placed hospitals. They also pointed out that one of the most serious difficulties of such a program, especially if many new hospitals were built, would be to find properly trained personnel to man them and they suggested that provision might be made to train hospital personnel at Government expense. Your Committee also urged that existing public hospitals should be utilized to their full capacity before new ones were built and that the Government might well subsidize these.

It seems to your Committee that the Government is now attempting to carry through piecemeal the program proposed in the original Wagner act. This is shown by the introduction of two sets of bills during the present session of Congress: (1) S. 3230, introduced by Senator Wagner for himself and Senator George of Georgia. Representative Lea of California has introduced a companion bill in the House of Representatives (H.R. 8240). (2) S. 3246 introduced by Senator Mead of New York. Representative Schulte of Indiana has introduced a companion bill in the House (H.R. 8288).

The bill introduced by Senators Wagner and George is entitled "A Bill to promote the National Health and Welfare through Appropriation of Funds for the Construction of Hospitals" and it covers ground already covered in the original Wagner act and discussed at the beginning of this report. In essence it is the portion of the original Wagner Act referring to the construction of Hospitals with certain changes of which the most important are: — (1) the appropriation of $10,000,000. to the U. S. Public Health Service for the fiscal year ending June 30, 1941, for carrying out the purposes of the Act, (2) the creation of a mechanism whereby states, counties or cities, alone or in combination, may make written application for hospitals to the Surgeon General of the Public Health Service which must contain information showing the need of a hospital and giving assurance that such a hospital, if built, will be available to all groups of the population, will be maintained in good repair and will be utilized in furnishing service satisfactory in quality, in accordance with regulations to be prescribed by the U. S. Public Health Service, (3) the creation of a National Advisory Hospital Council consisting of the Surgeon General of the U. S. Public Health Service and six members to be appointed by him with the approval of the Federal Security Administrator. The members of this Council are to be selected "from leading medical or scientific authorities who are outstanding in matters pertaining to hospitals and other public health services." The members of the Council are to serve for three years. The purposes of the Council are: — (a) to review applications for hospitals and pass on their validity, (b) to formulate standards for the conduct of hospitals, (c) to formulate the rules and regulations necessary to carry out the act (d) to review hospital reports, including those on inspections and, if necessary, themselves to inspect hospitals.

The Surgeon General of the Public Health Service is authorized and directed, *after consultation with this Council,* (a) to conduct, assist and foster studies and surveys with respect to needs for hospitalization and problems of hospital operation, (b) to approve hospital projects and to designate the location, type, size and equipment of hospitals, (c) to allocate the funds for the construction of the same, (d) to provide training for hospital personnel, (e) to cooperate with state and local welfare authorities, (f) to secure reports bearing on manning and maintenance and to safeguard the quality of service provided in the hospitals, (g) to make the rules and regulations necessary to carry out the provisions of the act with the approval of the Federal Security Administrator anf (h) to *lease* the hospitals to local authorities when completed.

The hospitals are to be planned and built by the Federal Works Agency and the Federal Security Administrator is authorized to accept gifts of money, equipment or land for such hospitals.

As your Committee pointed out last year, there are regions in the United States which are in need of modern hospital facilities, and the new Wagner Hospital Bill provides a means whereby such facilities may be obtained through the federal government. The bill provides that diagnostic laboratories and health centers may be contained in the proposed hospitals. It also provides that if a hospital is not satisfactorily conducted, under the rules laid down by the Surgeon General, the lease to the local authorities may be terminated, but it does not state what will become of the hospital if this occurs. As outlined in the present bill the plan does not appear to have any very serious drawbacks, but it does throw a tremendous responsibility on the Surgeon General of the Public Health Service even though he has a board of Hospital Experts to back him up and advice him. While a definite sum is appropriated for the expenses of the first year the appropriations of the future are left in the hands of Congress. This plan has met with the approval of the American Medical Association and also with that of the newly formed National Physicians Committee for the Extension of Medical Service, an organization which may be mentioned here because it would seem that it is composed of individuals of responsibility and known interest in the welfare of the profession, and for this reason its decisions are likely to have weight in national legislation.

The Mead bill, entitled "The Health Security Act of 1940," is an omnibus measure authorizing a federal appropriation of $300,000,000 to be utilized in making *loans* to public bodies and non-profit organizations including hospitals, water sewerage systems, works controlling stream pollution and related facilities. Of this sum not more than $100,000,000 may be devoted to hospital projects. These loans are to be made by the Administrator of the Federal Works Agency and may be applied for by political agencies, states or their subdivisions, or by non-profit organizations. They are to be repayable within a period not to exceed 50 years and will bear interest at the rate of 2 per cent. Apparently under this law a loan could be granted for the construction of an entirely new hospital or for additions to an existing hospital. Any building erected in this way may, on the request of the Surgeon General of the Public Health Service, be commandeered by the Federal Government in time of war or of "National Emergency."

In submitting this bill Senator Mead pointed out that it will in no wise conflict with Senator Wagner's Hospital Bill but will rather be supplementary to that measure.

Your Committee fails to see any serious menace to the free conduct of hospitals borrowing money under this plan although the right of the Government to commandeer under a condition of "National Emergency" is somewhat vague as no effort is made to define what sort of conditions would be likely to be defined as "National Emergencies."

We think it can be said truly of both these measures that while they are not perfect they have safeguarded much more adequately than did the original Wagner bill the projects which they aim to create.

WALTER R. STEINER
GEORGE BLUMER

SIXTH ANNUAL REPORT OF THE TUMOR COMMITTEE

There has been but one meeting of the State Tumor Committee during the past year due to the fact that the committee has delegated the necessary work for carrying out the purposes of this organization to subcommittees. The Tumor Committee itself now acts simply as an advisory and governing committee.

The *Executive Committee*, (Dr. Charles L. Larkin, Dr. Philip G. McLellan and Dr. E. J. Ottenheimer) has continued to discharge its duties which are to see that the suggestions of the Tumor Committee are carried out, to approve all work submitted by subcommittees and the Division of Cancer Research and to edit all material submitted for publication. Undoubtedly the largest and most effective piece of work accomplished during 1939 was the editing, printing and distribution to all physicians in the state of the Cancer Handbook, which was written from the material submitted by committees made up of members of the State Medical Society who are particularly versed in oncology. This Handbook therefore represents the best opinions that have been obtainable on these particular subjects. It was only through the conscientious and unfailing assistance of the Cancer Division of the State Department of Health that the Executive Committee was able to bring to completion this weighty task.

The three main subdivisions of the Tumor Committee, the Scientific and Publicity Committee and the Division of Cancer Research have been especially active this year.

The *Scientific Committee*, under the chairmanship of Dr. Ralph E. Kendall, (members: Dr. E. C. Weise, Dr. J. C. Mendillo, Dr. Paul Rosahn, Dr. F. A. Sutherland, Dr. K. K. Kinney, Dr. C. J. McCormack) has had but moderate activity, owing to the difficulty of obtaining adequately attended meetings. The committee has two problems which it is working on: (1) the classification of tumor clinics and standardization for each type; (2) the investigation of the necessity for a diagnostic out-patient type of tumor clinic.

The Publicity Committee, under the chairmanship of Dr. E. J. Ottenheimer (members: Dr. Stanley Osborn, Dr. Carl Johnson, Dr. W. W. Dinsmore, Mr. Herbert Hirsche), has had a very active schedule. In addition to aiding in the publication of the Cancer Handbook mentioned above, a great many talks have been given to various organizations throughout the state. The public demand for these talks has been increasing. Plans have been formulated and partially executed for writing and establishing a file of speeches on various topics pertaining to cancer which are to be enhanced by appropriate lantern slides representing not only statistical data, but also clinical material. These speeches will be available for the use of any member of the State Medical Society who has been requested to make a public address to lay or medical audiences. It is hoped that all physicians who are willing to participate in cancer publicity will avail themselves of these speeches in order that the propaganda put forth will be recognized as officially approved. During the coming year, it is planned to conduct cancer meetings in cooperation with the State Medical Society similar to the pneumonia program which was carried out in the past year, before the various county organizations.

The committee is making a drive to induce all practicing physicians in the state to establish the custom of sending out annual physical examination appointment cards. This phase of the work has already been completed in Waterbury and its suburbs and the physicians in this territory have shown a great willingness to cooperate and many of them have already adopted the plan. During this coming year, it is planned to contact the physicians in every large community in the state and assist those willing to cooperate in setting up a filing system.

During the past year, the work of the *Division of Cancer Research* of the State Department of Health has been carried on along the same lines as in the past with the exception that there has been added the photographing, coding and card punching of standard tumor record forms from the various clinics throughout the state. This work involved the formulation of a code whereby the information could be transferred to punch cards, and the establishment of a standardized nomenclature of tumor pathology. The actual photographing and coding of these records begun this year is a definite milestone in the progress of the cancer program in the state.

The usual statistical functions of the Division have been carried on as in the past and plans have been laid to begin the work of adjusting mortality rates for both age and sex and possibly to undertake a study of cancer among the various nativity stocks comprising the population of the state. It is hoped that some of the phases of this work can be done by the Department of Public Health at Yale, and Dr. Watkins, Professor of Vital Statistics, has expressed his willingness to cooperate with us in this effort.

Lantern slides of numerous charts, maps and graphs, depicting graphical representations of cancer statistics have been prepared and used during the year for educational purposes.

One of the major efforts of this Division was the printing and distribution of the Cancer Handbook, copies of which have already been distributed to all members of the medical profession in the state and arrangements are being made to send it to other interested people. It is also probable that it will be possible to furnish copies to the medical students at Yale and perhaps to internes in hospitals throughout the state.

The various clinics throughout the state have been furnished with standard tumor record forms, follow-up letters and various other material assistance. Numerous visits to the clinics have been made by the personnel and assistance rendered in regard to records and other phases of the problem. Numerous requests for follow-up information on cancer cases have been answered.

The education of the public in regard to cancer has been carried on through three mediums, the written word, the spoken word, and the radio. Articles on cancer have been submitted for publication in the monthly and weekly bulletins of the department, and these articles have been rewritten in newspaper style and submitted to the press.

A few articles of a more technical nature have been submitted to the Journal of the State Medical Society and have been accepted.

So far this year, since July 1st, sixty lectures on cancer have been delivered in the state; fifty-three by personnel of this Division and seven by others. Five lectures are scheduled for the immediate future in this state and one in Rhode Island. Plans have been made to increase the lay educational phase of the program, and it is expected that the year 1940-41 will show a marked growth in the amount of information disseminated.

The *Association of Connecticut Tumor Clinics* has functioned as energetically as formerly. The annual meeting was held on September 22, 1939, and three meetings in different hsopitals have been held during the winter and a fourth is to be held in May. The programs presented at these meetings are listed under the Program Committee.

The reports of the four subcommittees of the Association are as follows:

Record Committee: members, Dr. Christopher J. McCormack, chairman, Dr. Matthew Griswold, Dr. John C. Mendillo, Dr. W. Bradford Walker, Mr. Herbert Hirsche. During the past year, the Tumor Clinics throughout Connecticut have continued to make use of the forms devised by this committee and supplied by the Division of Cancer Research to record important data relative to cases of cancer. On the whole these forms are serving their purpose very well, but means for further increasing their efficiency have been discussed by the committee. During 1939, the recording and coding of tumor cases by the division of Cancer Research has been begun and already the 1938 records of eight tumor clinics have been photographed and recorded on punch cards. An attempt is being made by a special committee to draw up a suitable record form to be used not only by the hospitals but by the general practitioners for recording the histories and also physical examinations of patients. Such forms will be needed in connection with the yearly examination.

Therapy Committee: members, Dr. B. M. Parmelee, chairman; Dr. E. J. Ottenheimer, Dr. A. W. Oughterson, Dr. Ralph Ogden, Dr. L. P. Hastings. This committee has had no meetings during the past year and has made no progress due to the fact that it was thought that the proper activity would be to review the Cancer Handbook after publication, and to start making plans for the possible second edition.

Pathology Committee: members, Dr. Robert Tennant, chairman; Dr. L. P. Hastings, Dr. Paul Rosahn, Dr. J. O. Collins. The committee has continued to sponsor the monthly informal meetings of the pathologists of the state as in previous years. These have been held in Brady Laboratory and have been well attended. These sessions have been devoted primarily to the presentation of interesting pathological material and problems, but from time to time a portion of the session has been devoted to the demonstration of slide collections of tumors from various organ systems.

The Nomenclature of Neoplastic Diseases, which was prepared and revised last year, was distributed to all of the clinics in the state. Starting with January 1939, each clinic has been coding the malignant tumors according to this system.

A uniform method of tabulating autopsy findings in cancer cases in a way that could easily be adapted to classification and coding has been discussed. Dr. Paul Rosahn has been appointed to investigate such existing forms as are available from other places with the hope of eventually evolving a suitable one for our needs.

Program Committee: members, Dr. A.W. Oughterson, chairman; Dr. Carl H. Wies, Dr. K. K. Kinney, Dr. R. T. Ogden, Dr. E. C. Weise, Dr. E. W. Foster, Dr. Paul D. Rosahn. The first of the four regular meetings of the Association of Connecticut Tumor Clinics was held in New London at the Lawrence and Memorial Hospitals Associated, Inc., on November 3, 1939, under the chairmanship of Dr. Carl H. Wies. The program was as follows:

1. Introduction — C. H. Wies, M.D.
2. Carcinoma of the Breast — George C. Cheney, M.D.
3. An Unusual Case of Melanoma — Frederick Hartman, M.D.
4. Carcinoma of the Cervix — Charles Kaufman, M.D.
5. General Discussion

The second meeting was held in Waterbury at the Waterbury Hospital on December 13, 1939, under the chairmanship of Dr. Charles L. Larkin. The program of this meeting deviated somewhat from the usual form, in that a model clinic was held, such as is conducted weekly, preceeded by an explanation and description of the methods used in the functioning of the clinic and the procedures employed in the record and follow-up systems.

The program was as follows:

Follow-up Cases

1. L. C. Chorio-epithelioma of uterus — Dr. H. J. Corbett, Dr. John Freiheit.
2. N. A. Carcinoma of the Breast — Dr. A. E. Herrmann, Dr. Wm. A. Goodrich.
3. L. K. Bowen's Disease — Dr. R. J. Lawton
4. L. R. Carcinoma of the Testis — Dr. H. J. Stettbacher, Dr. C. N. Neuswanger
5. L. M. Carcinoma of the Cervix — Dr. L. Backhus, Dr. Roger Nelson

New Cases

1. A. G. Abdominal Mass — Dr. Thos. Cottiero, Dr. H. J. Stettbacher, Dr. A. E. Sirica.
2. M. H. Dercum's Disease and question of intracranial lesion — Dr. Arthur Jackson, Dr. S. M. Atkins, Dr. C. L. Larkin, Dr. T. Bevans.
3. F. S. Tumor of Kidney — Dr. H. G. Atha, Dr. C. N. Neuswanger.

Clinical Pathological Conference

Dr. E. H. Kirschbaum and Dr. O. J. Bizzozero

Organization of a Tumor Clinic — Dr. Charles L. Larkin
Routine and Records — Mrs. Douglass O. Burnham
Planning of Program — Dr. Elliott R. Mayo

The third meeting was held in Meriden at the Meriden Hospital on April 7, 1940, under the chairmanship of Dr. E. W. Foster. The program was as follows:

1. *Gynecological Cases*
   Review of Cases of Carcinoma of the Ovary — E. W. Foster, M.D.
   Sarcoma of the Uterus — Averill Liebow, M.D.
2. *Care of Inoperable Cancer*
   The Medical Viewpoint — T. P. Murdock, M.D.
   What the Neurological Surgeon can Offer — Max Taffel, M.D.
3. *Crymotherapy*
   Presentation of Apparatus — D. P. Smith, M.D.
4. *General Discussion*

The fourth and last meeting is to be held in New Haven at the New Haven Hospital on May 2, 1940, under the chairmanship of Dr. A. W. Oughterson. The program is to be as follows:

Problems and Errors in Diagnosis of Malignant Tumors

Tumors of Central Nervous System — Max Taffel, M.D.
Tumors of Lung — Gustaf E. Lindskog, M.D.
Tumors of Kidney — Clyde L. Deming, M.D.
Tumors of Uterus — Arthur H. Morse, M.D.
Tumors of the Gastro-Intestinal Tract — A. W. Oughterson, M.D.
The Connecticut State Tumor Program — Herbert F. Hirsche

The *Radium Loaning Committee*, under the chairmanship of Dr. P. G. McLellan, and consisting of Dr. Christopher J. McCormack, Dr. R. E. Ogden, Dr. A. W. Oughterson, Dr. B. M. Parmelee, which was appointed over a year ago for the purpose of cooperating with the National Cancer Institute in dispensing radium to the various hsopitals requesting it, has been completely inactive owing to the fact that the National Cancer Institute allotted the radium without consulting either the committee or the Cancer Division of the State Department of Health.

CHARLES L. LARKIN
Chairman

* * * *

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations met in New Haven on December 20, 1939. Five of the seven members attended. The chief business of the meeting was to view the cinema "The Birth of a Baby" and to take action on a motion of recommendation for public showing of the film. It was voted to approve the public exhibition of the film subject to the provisions written in the contract relative to the distribution of the picture. The meeting was otherwise devoted to a presentation from each member of the methods employed in his particular county "to enlighten and direct public opinion in regard to the problems of medicine and health for the best interests of the people of the State." The report of the numerous and significant activities of the Medical Information Bureau of the Hartford Medical Society and the Hartford County Medical Association met with particular approval. It was voted to lend whatever help and cooperation the Committee of the State Medical Society might be able to further the projects of the various city and county organizations in public education.

The Committee is actively engaged in establishing a "speaker service" for lay organizations and in this connection was able to respond to the request of the Hartford Kiwanis Club by securing Dr. Peter Irving, Secretary of the Medical Society of the State of New York and Dr. Irving Clark of Worcester, Massachusetts, authority on Industrial Medicine, as luncheon speakers. The broadcast of Dr. Morris Fishbein's address at the midwinter dinner of the State Society was arranged through the efforts of Dr. Harry L. F. Locke, member from Hartford County. The Committee received a letter from the editor of a publication concerned with Connecticut news, apologizing for an indiscreet item effecting one of the members of our State Society and expressing a wish to cooperate fully with the Society in respect to future publications concerning physicians of Connecticut.

Through the generous interest and active assistance of Dr. Creighton Barker, Executive Secretary of the Society, the Committee is planning to extend its activities as opportunities may offer. It is the sense of the Committee that much can be done to keep the importance of the medical viewpoint before the public and to coordinate the various projects for public enlightenment in the several counties. The Committee welcomes any opportunity to cooperate with local organizations to this end.

Respectfully submitted,
CLARENCE L. ROBBINS

* * * *

REPORT OF DELEGATE TO ANNUAL MEETING OF THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

In May, 1939, as a delegate from The Connecticut State Medical Society, I attended the Annual Meeting of the Connecticut Pharmaceutical Association.

My very definite impression is that the exchange of delegates between the Connecticut State Medical Society and the Connecticut Pharmaceutical Association has furthered their mutual understanding. A year ago I reported to you and the House of Delegates, as Chairman of the Narcotic Committee, that we were unable to formulate a law designed to control the sale of barbiturates and other dangerous drugs which would be satisfactory to a majority of the physicians and the pharmacists. Since then the Pure Food and Drug Act has been passed without the study by and knowledge of the Narcotic Committee and its Chairman. I have the impression that some of the pharmacists feel this Act was supported behind their backs by our Society.

In any event, the present law should have a restraining influence on the indiscriminate use of hypnotics and dangerous drugs by the laity. It is my recommendations that the policy of exchange of delegates be continued and that the Chairman of the Narcotic Committee continue to be appointed the delegate from The Connecticut State Medical Society.

Very truly yours,
ARTHUR B. DAYTON

* * * *

REPORT OF THE DELEGATE TO THE CONNECTICUT DENTAL ASSOCIATION JUNE, 1839

Mr. President and Members of the House of Delegates:

I had the pleasure of addressing the House of Delegates of the Connecticut State Dental Association at Bridgeport in June 1939, and extending to them the greetings from The Connecticut State Medical Society which were received with enthusiasm. I received a very cordial reception and had the privilege of attending their banquet on the last day of their meeting.

Respectfully submitted,
JAMES D. GOLD

ANNUAL REPORT OF THE PUBLIC HEALTH COMMITTEE

The Public Health Committee of the Connecticut State Medical Society has held three meetings during the winter. The problems discussed were chiefly those relating to maternal and child welfare, together with some discussion on the venereal disease problem.

Very often the recommended treatment in a serious obstetrical case requires hospitalization. Because of the financial standing of the patient, the doctor finds himself handicapped in carrying out proper care. It is the feeling of this Committee that whenever such a patient requires hospitalization, that transportation to the hospital and hospitalization in the public wards under staff care be paid for by the Bureau of Child Hygiene. It shall be the duty of the attending physician to take the responsibility of estimating the financial status of the case concerned. These patients shall be transported only to hospitals meeting the minimum requirements for maternity hospitals, as designated by the State Department of Health.

It was proposed and accepted by the Committee that a nursing service be established in all communities of Connecticut with a population of less than fifty thousand. The object of this nursing service would be to give graduate nurses a little additional training and regular supervision, so that they may be available to assist at home deliveries and that they shall be paid $5.00 for eight hours of service. It was also proposed that these nurses may be engaged on an hourly basis and that the service be extended to paupers where no provision for nursing services by the town is furnished.

It is the feeling of this Committee that special effort shall be made in the care of the premature infant. It is proposed, therefore, to develop a program which will include the payment for hospitalization of premature infants in the general wards of the hospitals. In those instances where the premature infant must be transported to a hospital, that hospital must fulfill the minimum requirements for licensing maternity hospitals. Under the minimum hospital requirements in the care of prematures the acceptable hospital must have:

1. A member of the pediatric consultant service on the staff.
2. A separate nursery for premature infants.
3. They must meet the minimum requirements of the Sanitary Code of the State.

Concerning the authorization of bills for the care of the infant while in the hospital, the consultant shall have the power of authorizing the payment for four days, but the Bureau of Child Hygiene may extend this time.

Since one of the most important factors in the care of prematures is the maintenance of a constant body temperature, the necessity of supplying incubators has been considered by the Committee. A home-made incubator such as is now being used in Massachusetts has been constructed and approved by the Committee. These incubators shall be used for the transportation of prematures to hospitals and shall be placed in the various hospitals throughout the state.

In the event that a pediatric consultant is called to see a premature infant at home, he shall be paid a fee of $5.00, and $3.00 for each subsequent visit to a total not exceeding $20.00 per case, with an additional allowance of 5 cents per mile for travel from his office to the patient's residence and return. These pediatric consultants shall be appointed by the pediatric sub-committee of the Public Health Committee, and it is recommended that each prospective consultant be a member of the American Board of Pediatrics or eligible for admission to the Board, and that he submit a record of his training and experience. A survey of the state shows that there are instances in which this is not always possible and, therefore, the pediatric sub-committee shall select physicians whom they feel are capable of handling this problem. The pediatric consultants are to be called directly by the attending physician. The families of the children will be self-supporting but unable to pay for necessary medical care. In other words, they will be families who are not on relief and for whom no other provision has been made for special medical care by local agencies. The attending physician shall be responsible for estimating the financial eligibility of these cases.

The Bureau of Child Hygiene is preparing special courses for nurses on the care of premature infants to be established in various parts of the state as a way of improving nursing care, both in hospitals and at home. Attendance at these centers will be recommended to nurses who are regularly assigned to the care of premature infants in all maternity hospitals in Connecticut.

The establishment of educational training centers for well-child conferences is an important step in the proper care of infants and young children. Many physicians in the state are desirous of attending these conferences, but the distances are so great they are prevented from doing so. A plan is therefore proposed that these conferences be established in several localities so that no man will have to travel more than twenty-five miles to a training center. Whenever possible, the men in charge of well-child conferences shall be licentiates of the American Board of Pediatrics. However, since this is impossible in all sections of the state, the pediatric sub-committee shall select a physician whom they feel capable of being in charge of the conference. With regard to physicians attending well-child conferences, the Committee feels that if the doctor remains an hour, or a sufficient length of time to examine the infants and pre-school children carefully, he will be paid $5.00, except at training centers.

On the suggestion of the Surgeon General, Doctor Parran, the State Department of Health was invited to participate in a state-wide evaluation of laboratories performing tests for syphilis. Under the present Sanitary Code a number of laboratories are allowed to function without the approval of the State Department of Health. It is hoped in the state-wide evaluation of laboratories that enough material might be obtained which would be of some aid in changing the law whereby all laboratories performing tests for syphilis must be approved by the State Department of Health.

This Committee also feels that all treatment stations for syphilis should be carefully supervised by the State Department of Health, since it is obvious that treatment stations in small communities are run by men who could not be considered experts in the management of syphilis. It is felt that upon admission of a new patient to these treatment stations, the physician in charge and a representative of the State Department of Health should outline the general plan of treatment which is to be followed. Physicians operating treatment stations and failing to co-operate in carrying out treatment, or in rendering proper reports may be justifiably dropped by the Division of Venereal Disease of the State Department of Health, after consultation with the Committee of Public Health of the State Medical Society.

The greater portion of our work has been in the field of maternal and child health. Connecticut is leading the way in the reduction of maternal and infant mortality. It is only through the enthusiasm of the members of this Committee and the splendid cooperation with the Bureau of Child Hygiene of the State Department of Health that we are able to report such excellent results in the reduction of maternal and infant mortality.

Respectfully submitted,
JOSEPH H. HOWARD

* * * *

REPORT OF THE DRUG AND NARCOTIC COMMITTEE

This Committee was appointed at the 141st Annual Meeting of the Connecticut State Medical Society in May, 1933, on the recommendation of the Council in order to carry out recommendations of the Committee on National Legislation of the American Medical Association, with the aim of studying the narcotic problem in Connecticut, and, cooperating with the Committee on Public Policy and Legislation, to secure enactment of the Uniform Narcotic Act for this state.

There was a careful study by means of questionnaires to doctors and hospitals, conferences with Federal and American Medical Association representatives, visits to Norwich State Hospital, Wethersfield State Prison and some private institutions, and by close cooperation with the State Board of Health.

The Uniform Narcotic Drug Law was passed by the Legislature in the 1935 session, essentially as recommended by the State Medical Society. A narcotic agent, Mr. Arthur J. Rivard, was appointed late in 1935, serving under the Bureau of Preventive Diseases, with Dr. Millard Knowlton as Director.

Table

Year	*No. Narcotic cases handled*	*Cases referred to Federal Bureau*
1937	28	8
1938	40	20
1939	48	16

This table represents the number of new narcotic cases handled by the Department during each of the last three years. According to the Federal Narcotic Bureau in 1938, Connecticut had 251 narcotic addicts, an incidence of 1.33 per 10,000 population which is one of the lowest rates for any state. This problem seems to be well under control and the law being administered efficiently.

At present, the greatest difficulty in carrying out the law is the lack of suitable means for handling male addicts. The women may be committed to the State Farm in Niantic by any of the Courts of Criminal Jurisdiction, but with the closing of the State Farm for Inebriates at Norwich this past year, there is now no place to which a male addict may be committed by the Criminal Courts. The Committee is at present cooperating with Dr. Knowlton and his department in working out a solution to this problem.

The second problem confronting the Committee is the question of barbiturates. It is felt by some that the habit forming aspect of this group of drugs is potentially almost as serious as the narcotics. Some states, New York and Massachusetts included, allow druggists to dispense these drugs only on a physician's written prescription. This Committee recommended last year that such a law be enacted in Connecticut. This was rejected on the ground that, as worded, it could not be passed by the Legislature. The law would be opposed by the pharmacists who would feel that they were being discriminated against in favor of the dispensing physician and by legislators themselves who did not want their freedom to use these commonly used drugs restricted. The Committee again recommends that such a law be passed.

The question of the barbiturates and most of the newer so called "dangerous drugs" — sulphanilamide, cinchophen, aminopyrine, etc. — was at least temporarily taken out of the hands by the passage by the United States government under the Department of Agriculture of the Pure Food, Drug and Cosmetic Act, June 29, 1939, and also by the passage by the Connecticut State Legislature in 1939 of the Dairy and Pure Food Laws. Both of these laws were passed without consultation with the State Medical Society or with the Connecticut Pharmaceutical Association. The Connecticut laws apparently follow closely the Federal Law. These laws went into effect January 1, 1940. On the whole, the laws seem excellent and are meeting the whole-hearted approval and cooperation of physicians and druggists throughout the state. It is too soon to make any accurate observation or draw any conclusions regarding the working of the laws. It is estimated there are some 250 changes in procedure required for the pharmacists resulting from the change in laws.

One difficulty arises from the fact that this drug law is incorporated in the Dairy Law and is under the jurisdiction of the Dairy Commissioner. We feel that the drug and cosmetic feature of the Act belongs to the Department of Health and should be administered by the Commissioners of Health. The Committee recommends that the coming legislature make the necessary legal alterations to bring this about.

There should be noted an increasing spirit of cooperation between the pharmacists and physicians in the state. Dr. A. B. Dayton of this Committee was a delegate of the Connecticut State Medical Society at the Annual meeting of the Connecticut Pharmaceutical Association in June, 1939, and gave an address on barbiturates and sulphanilamide. An interesting experiment in mutual cooperation was tried in New Haven last year when a meeting of representatives of the New Haven pharmacists and physicians was called to discuss the demand for benzedrine by students at examination time. It was voluntarily agreed that benzedrine would only be dispensed on prescription. This has been carried out satisfactorily to both parties.

Plans are now under way for furthering closer cooperation between the Connecticut Pharmaceutical Association and the Connecticut State Medical Society by the appointment of special conference committees and by exhibits and exchange of representatives at annual meetings.

By the Committee:
JOHN H. FOSTER, Chairman
A. B. DAYTON
CHESTER WATERMAN
ALFRED LABENSKY

* * * *

REPORT OF ADVISORY COMMITTEE TO NURSING EXAMINING BOARD

The members of the Hospital Association and the Medical Association conferred with the Legislative Committee of the Connecticut State Nurses' Association when the proposed legislation for the 1939 Legislature was being formulated. In order to insure continuity of help from these organizations in problems which are of mutual interest, it was voted to appoint an Advisory Committee to the Board of Examiners for Nursing. This committee was to consist of two members each from the Connecticut Hospital Association, the State Medical Association, and the Connecticut State Nurses' Association. The members appointed by the above organizations include Dr. B. Austin Cheney and Dr. Claude C. Kelly of the Medical Association; Albert Buck and Ellen McIntyre of the Hospital Association; and Marion Douglas and Ethel P. Clarke of the Connecticut State Nurses' Association.

Meetings of the committee have been held as follows: June 28, September 14, December 15, and February 29. At the first meeting, the committee was organized. Miss Irene Wilson was chosen President and Miss Agnes Ohlson was chosen Secretary. The objectives were outlined by the committee as follows:

1. To acquaint members of the committee with the activities and function of the Board of Examiners for Nursing:
2. To acquaint members of the committee with problems of administration of the law;
3. For committee members to interpret the work of the Board to their organizations;
4. To study legislation that concerns the care of the sick.

The committee felt that the continuity of membership was important. Therefore, of the members now appointed, one from each organization will serve for three years and the second member will serve for a two-year period and that subsequent members will be appointed for a two-year period, thus insuring a two-year rotating membership.

The items discussed have included the following: academic requirements for students entering schools of nursing; the possibility of schools of nursing utilizing college facilities within the state; publicity for the trained attendant waiver; method of evaluating trained attendant waiver applications; need for further study of the facilities available for preparing individuals to care for the sick so as to determine if we can with our present legal requirements properly meet the community nursing needs; revision of topics for examination for nurses; discussion of the practical nursing schools on the state, and discussion of the enforcement of citizenship requirements.

The undersigned was present at all meetings.

Respectfully submitted,
B. AUSTIN CHENEY, Chairman

* * * *

REPORT OF COMMITTEE ON COOPERATION WITH YALE MEDICAL SCHOOL

Mr. President and Members of the House of Delegates:

This dual committee has not had its two stipulated meetings during the past year for various reasons. The one problem presented involved the New Haven Hospital more than the School of Medicine and at the suggestion of Doctor Bayne-Jones the Council met with the professional members of the Medical Board of the Hospital.

The point at issue was the change in relationship between the New Haven Hospital and the Plan for Hospital Care which arose out of the installation of an all inclusive rate of payment by patients in the New Haven Hospital. The House of Delegates at its annual meeting in 1937 placed itself on record as approving prepayment plans for hospital care only when such plans did not include any medical service other than that customarily given by a resident house staff. Under the inclusive rate of payment now in operation in the New Haven Hospital certain medical services, including x-ray and electrocardiography, are covered in the payments made by the patients. To meet this circumstance the Plan for Hospital Care has agreed to pay the New Haven Hospital under a somewhat complicated system, for a part of these medical services. This was deemed contrary to the policy established by the House of Delegates in 1937 and an attempt was made to clarify the situation and bring the relationship between the Plan for Hospital Care and the New Haven Hospital into agreement with that policy. It affects no other hospital except the New Haven Hospital. Up to the present no conclusion satisfactory to all of the parties concerned has been reached. Further exploration of the subject is required.

Throughout the conferences and discussion of this confusing subject the Council has not retreated from the position taken by the House of Delegates of the Society and the problem still remains a disagreement between the policy of this House and the procedure followed by the Plan for Hospital Care in this instance.

Respectfully submitted,
JAMES D. GOLD, Chairman

* * * *

REPORT OF THE CHAIRMAN OF THE COMMITTEE ON INDUSTRIAL HEALTH

There have been a number of definite steps taken by this Committee during the past year, which it is hoped will further the interests of industrial health in Connecticut. Much remains to be done, but a start appears to have been made and it is felt that the time for widely expanded activity may not be far distant.

At the first meeting of this Committee on November 29, 1938, four concrete suggestions were made. Two of these had been acted upon at the time of the report to the House of Delegates last year. The other two, which have now been acted upon, were: (1) A health committee for the Manufacturers Association of Connecticut should be recommended in due time and (2) There should be an informal group within the State Society of doctors interested in industrial medicine.

At the Committee's request the President of this Society recently wrote the President of the Manufacturers Association respectfully suggesting that the Association appoint a health committee to confer with this Committee. The President kindly and enthusiastically replied that he had had such a committee in mind for some time and had already asked F. U. Conard, vice-president of Underwood-Elliott-Fisher Company of Hartford to act as chairman. As soon as the personnel of the committee is announced a joint meeting is contemplated.

In respect to the remaining suggestion, referred to,it is planned to hold the first meeting of an Industrial Health Section of this Society on Wednesday, May 22, at 2:30 p.m. in connection with the Annual Meeting of the Society. During the past summer a list was compiled of Connecticut physicians and surgeons who spend part or full time actually on the premises of an industrial organization. These physicians, as well as others known to be "on call" or who serve industry casually, have been invited to attend. The lists are still in process of compilation and it is hoped that industrial physicians will make themselves known to the Committee.

The letter of invitation to the physician contained a questionnaire asking what specific phase of industrial medicine interested him. The returns are now being studied.

The Committee is cooperating with the Program Committee of the Clinical Congress and expects to arrange for an outstanding speaker to address the next Clinical Congress on the subject of industrial health.

This season's meeting of the Committee was held in Meriden on January 23, 1940, at the home of Dr. Cole B. Gibson, who had been the Committee's host previously. At the meeting Dr. Albert S. Gray and the Chairman reported on the papers read at the second Annual Congress on Industrial Health, held in Chicago, January 15 to 17, 1940. An Executive Committee was formed for more frequent meeting, for consultation on matters of policy and for quicker action. Doctors Cole B. Gibson, Albert S. Gray and Richard O'B. Shea were appointed to the Executive Committee; the Chairman of the Committee, the President of the Society and the Executive Secretary of the Society serving ex-officio.

At the round table discussion at the second Annual Congress on Industrial Health the Chairman of the Committee read a paper, entitled "Organized Medicine and Industrial Health."

The Committee has been encouraging an educational program beginning with the January, 1940, issue there have appeared four articles in the Connecticut State Medical Journal on the subject of industrial health and one editorial.

The Chairman of the Committee prepared a signed article on industrial health for the Health Number of the New Haven Sunday Register, which was omitted for lack of space, but which appeared as an interview a few days later in the evening edition of March 1, 1940.

The Chairman's article in the February 1940, issue of the Connecticut State Medical Journal, entitled "Industrial Medicine of Tomorrow" was reprinted by the New Haven Y.M.C.A. in their "Industrial Recreation Weekly Bulletin."

The Chairman spoke before the Hartford Industrial Nurses Club and the Southern Connecticut Branch of the New England Industrial Nurses Association at the New Haven Country Club on April 13, 1940, and also delivered a lecture at the Tenth New England Health Institute on April 16, 1940, in both instances the subject being "New Developments in Industrial Medical Service." That part of the Institute's program devoted to industrial hygiene was made the subject of a special bulletin broadcast by the Manufacturers Association of Connecticut to their membership and the program was also published in the Association's monthly periodical, "Connecticut Industry."

The library of industrial medical literature is constantly being enlarged.

Respectfully submitted,
CLIFFORD KUH

* * * *

REPORT OF WORKMEN'S COMPENSATION COMMITTEE

Mr. President and Members of the House of Delegates:

This Committee has been in a state of lassitude for the past three years due to the lack of interest of the district committees. Because of this inactivity I addressed a letter and questionnaire to each committee member asking the following questions:

1. Should the Society have a standing committee on workman's compensation?
2. Should the present five congressional district committees be continued or one statewide committee be instituted?
3. If a standing committee on workmen's compensation is provided, to what problems do you think it should direct its attention?
4. Would you be interested in serving on the Society's Committee on Workmen's Compensation.

From the 25 letters sent out, 19 replies were received.

1. It was practically unanimous that there should be a standing committee on workmen's compensation.
2. The majority favored a single committee.
3. The suggestions were varied and no definite conclusion could be drawn.
4. About one half replied that they would be willing to serve.

From the infromation gathered here it seems advisable to recommend to the House of Delegates that the congressional district committees be omitted and one central committee made up of two members from each congressional district be appointed.

Respectfully submitted,
JAMES D. GOLD, Chairman

* * * *

REPORT OF DELEGATES TO VERMONT STATE MEDICAL SOCIETY

House of Delegates of the Connecticut State Medical Society.

Gentlemen: Your delegates to the Vermont State Medical Society attended its One Hundred and Twenty-

Fifth Session in Burlington, Vermont, on October 5th and 6th. We were cordially welcomed by the Association and listened to an interesting program which extended over the whole of Thursday and Friday morning. The President, Dr. Edwin A. Hyatt, of St. Albans, was unfortunately prevented from attending on account of illness, and the meetings were conducted by the Vice-President, Dr. Angus C. Black, of Brattleboro.

On the morning of the first day the Vice-President's address on urinary calculi was read and interesting papers on the damaged shoulder, by Dr. David Bosworth, of New York, and on tumors of the breast, by Dr. John F. Erdman, of New York, were presented and discussed.

In the afternoon Dr. Harry H. Kemp, the newly elected Dean of the University of Vermont Medical School, took the place of the President and gave an interesting talk on the future of medicine, especially from the educational standpoint. Dr. Edward Archibald, of Montreal, who had addressed the Society at its One Hundredth Anniversary twenty-five years ago, spoke on the surgical treatment of appendicitis, and Dr. Nathan B. Van Etten, President-Elect of the American Medical Association, gave an interesting talk on the quality of medicine. The afternoon was closed with a paper by Dr. William Raab on arterial hypertension of cerebral origin. The annual banquet was held in the evening.

The entire morning of Friday, October 6th, was taken up by an obstetrical symposium on the toxemias of pregnancy and bleeding in late pregnancy.

The meetings were well attended and the papers were interesting and actively discussed.

GEORGE A. GOSSELIN
GEORGE BLUMER

* * * *

REPORT OF DELEGATE TO THE MASSACHUSETTS MEDICAL SOCIETY 1939

It was my pleasure to attend the meetings of the Massachusetts Medical Society at Worcester on the final day, June 8, 1939.

Three interesting papers were presented at the Section on Obstetrics and Gynecology. In discussing the maternal mortality for Massachusetts it was of interest to note that the speaker held up the figures for the previous year in Rhode Island as an example of what could be attained when as a matter of fact our own maternal mortality rate in Connecticut was even lower.

Considerable surprise was evidenced when your delegate responded to the call for visiting delegates. No delegate from any other State Medical Society appeared at the business meeting. The program closed with a very excellent presentation of the problem of socialized medicine in relation to the Massachusetts Medical Society by Doctor Elliott P. Joslin of Boston. Sixty-four firms were represented in the commercial exhibits and twenty four excellent scientific exhibits were displayed.

Respectfully submitted,
STANLEY B. WELD

LIST OF SUCCESSFUL APPLICANTS FOR LICENSURE AT MARCH 1940 EXAMINATIONS

Theodore A. Lynn — Hartford Hospital, Hartford
Hunt B. Jones — Hartford Hospital, Hartford
Siegfried Vogel — 31 Dwight St. New Haven
Robert Bozzi — 551 Howard Ave. New Haven
Luke J. Cerrone — Box 35A. Northford
Lazzlo Steinberger — 84 Kensington Terrace, Passaic, N.J.
Joseph A. Corey — 622 Baldwin St. Waterbury
Bruno Gerstl — 421 George St. New Haven
Kenneth F. Brandon — 128 Oxford St., Hartford
Leonard Scalzi — 841 Noble Ave., Bridgeport
Horatio C. Wood — 4401 Market St., Philadelphia, Pa.
Samuel A. Vetrano — 9 Russwin Road, New Britain
Isadore Friedberg — 162 Post Road, Darien
Alfred B. Dixon — 37 South High St., New Britain
Raymond G. Mainer — 44 Fairview St., New Britain
William P. Stetson — Grace Hospital, New Haven
Stanley J. Alexander — 111-50 76 Road, Forest Hills, N.Y.
Henry A. Arkless — 129 Dowd St., Newington
John R. Browning — Bellevue Hospital, New York
Ralph T. Collins — 54 Nepaug St., Hartford
John M. Cotton — 200 Retreat Ave., Hartford
Charles T. Desmond — 50 Willard St., Hartford
Joyce V. Deutsche — 115 York St., New Haven
Samuel Friedman — Fairfield State Hosp., Newtown
Forrest D. Gibson — 47 Willard St., Hartford
Norbert W. Humpage — 30 Oak St., Winsted
Harry Jacobs — Meriden Hosp., Meriden
Ralph J. Littwin — 789 Howard Ave., New Haven
William E. Moore — 333 Cedar St., New Haven
Jane E. Oltman — Conn. Farm for Women, Niantic
Alan A. Rozen — 224 Norton St., New Haven
Francis C. White — Uncas on Thames, Norwich
William M. Wiepert — 16 Lincoln St., New Haven

The PROFESSIONAL EQUIPMENT Co.
X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS.
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

- NEWS -
from County Associations

Fairfield

The Fairfield County Medical Association held its 148th Annual Meeting on April 9. The Association went on record as favoring the work of the National Physicians Committee for the extension of medical care. They approved the Committee's program for extending medical service to provide care for the indigent, and further approved the endeavor of the Committee which is concerned with countering destructive propaganda by acquainting the public with the methods and achievements of American Medicine. The following officers were elected: Berkley M. Parmlee, President; Ralph W. Crane, Vice-President; J. Grady Booe, Secretary; Clifton C. Taylor, Treasurer, and Samuel Mullins, Councilor. At the dinner following the meeting, the Society was addressed by Waldemar Kaempfert, Science Editor of the New York Times, on "The Quality of Medical Care."

On April 2, the Bridgeport Medical Association was addressed by Doctor Blake F. Donaldson, associate professor of clinical medicine, New York Post Graduate Medical School, on the subject of "Primitive Diet and Its Application to Medicine." Doctor Donaldson presented the subject in an interesting manner giving many of his own observations and opinions.

The Stamford Medical Society at its regular meeting on April 16 was addressed by Doctor Dudley J. Morton of New York on the subject of "Foot Disorders In General Practice."

Doctor Frank H. D'Andrea has been doing an excellent job in supplying news items from the Stamford area, as has been evident in this column during the past few months.

Doctor Charles A. Murphy of Stamford addressed the Annual Meeting of the Connecticut State Nurses Association at the Hotel Stratfield, Bridgeport, on March 28. His subject was "Pneumonia Treatment and the Nursing Care of the Child."

The Stamford bowling season was brought to an end with the annual bowling dinner held at the Hubbard Heights Golf Club on April 23. Doctor J. E. Starett took individual honors for the second successive year, with an average of 108. He was closely followed by Doctor J. J. Costanzo.

* * * *

Hartford

The Hartford Medical Society on March 18 was addressed by Doctor William D. Stroud, professor of cardiology in the Post Graduate School of Medicine of the University of Pennsylvania. He discussed Gall Bladder Disease in Relation to Conditions of the Heart.

Doctor Stroud emphasized the fact that there should be greater expression of optimism in the handling of all cardiac patients. Care should be taken not to restrict the individual's activity any more than is absolutely necessary. Activity rather than inactivity is conducive to better results.

The speaker went on to discuss coronary artery disease and agreed with various quoted authorities that disease of the gall bladder and chronic ulcer of the stomach and duodenum do aggravate an existing coronary artery disease.

Doctor Stroud gave an interesting clinic at St. Francis Hospital at which time two patients with hyperthyroidism were shown, their histories briefly discussed and their conditions discussed. Incidentally, these clinics are proving of great benefit and have been well attended.

The annual meeting of the Interne Alumni Association of St. Francis Hospital will be held at the Wampanoag Country Club on Tuesday, May 21, 1940, starting 6:30 P.M.

County members are urged to send in any items they think might be of interest for this column.

Doctor Frank H. Lahey, Director of the Lahey Clinic, gave an interesting Clinic at St. Francis Hospital on April 1, at 5 P.M. before a large gathering of physicians and nurses. Two patients were shown, one, a young girl with hyperthyroidism and the other, a man of 54 years who had been operated on successfully for a bleeding gastric ulcer. These cases formed the bases for an extended discussion by Doctor Lahey of problems involved in the diagnosis and treatment in hyperthyroidism and ulcer of the stomach and duodenum. In the evening at the Hartford Medical Society, again before a large gathering, Doctor Lahey covered many of the more recent advances in surgery and his remarks were illustrated and emphasized by the use of numerous lantern slides.

On May 6, the Hartford Medical Society will have the pleasure and benefit of hearing Doctor Warren H. Cole, professor of surgery of the University of Illinois. It is hoped that Doctor Cole will be able to give a clinic so that the series of clinics by guest speakers of the Society may go on without interruption. Announcement as to whether the clinic will be held at the Hartford or St. Francis Hospital will be made in due time for all who may desire to attend.

Doctor Frank O. Wood of Hartford is coauthor of a paper entitled, "Acute Abdominal Conditions Following Ovulation and Its Sequelae," which appeared in the New England Journal of Medicine, issue of February 1, 1940.

* * * *

Litchfield

The 176th Annual Meeting of the Litchfield County Medical Association was held at the Charlotte Hungerford Hospital Tuesday, April 23, following a luncheon at the hospital at 1:15 P.M. Routine business of the Association was transacted, including the election of officers for the coming year. The Presidential address was given by Doctor Edwin G. Reade of Watertown. The principal speaker of the afternoon was Doctor Ernest M. Daland of Boston, Director of the Westfield and Pondville Hospitals. Doctor Daland spoke on Cancer of the Breast.

Doctor Charles H. Turkington and Doctor M. E. Giobbe attended the meetings of the American College of Physicians held at Cleveland, April 2-5.

The monthly meeting of the Hospital Auxiliary was held on April 16 in the hospital auditorium with Mrs. Charles Bennett presiding. A valuable collection of modern surgical instruments was presented to the hospital by the Auxiliary. This organization is planning to continue its work in the care of the hospital grounds which it has sponsored and financed for the past two years.

* * * *

New Haven

Doctor Stanhope Bayne-Jones, dean of Yale University School of Medicine, was elected president of the American Association of Pathologists and Bacteriologists at its recent annual meeting in Pittsburgh. Doctor Bayne-Jones has been vice-president of the organization during the past year and a member of its council since 1937. He is also a member of the executive council of the Association of American Colleges.

The Waterbury Medical Association continues its estimable activities in public relations and enlightenment through the series of weekly broadcasts over Station W.A.T.R. at 5 o'clock on Tuesday afternoons and through the monthly Public Forums held at the Castle Memorial Building. During the winter months Waterbury citizens have heard at these evening meetings discussions of "Factors of Delay in Diagnosis of Cancer and other Surgical Conditions" led by Doctor Edward Ottenheimer of Willimantic, "The Relationship of X-ray Diagnosis to Public Health" by Doctor Hugh Wilson, associate professor of radiology at Yale, and "Diet and Vitamins in Health and Disease" by Doctor Maurice B. Strauss, associate in medicine at Harvard.

The regular monthly meetings of the Waterbury Medical Association have been addressed during the winter by Doctor Merrill Gosman of Harvard on "X-ray Findings in Cardiac Disease," by Doctor John A. Wentworth of Hartford on "Treatment of Pneumonia," by Doctor R. L. Leak, Superintendent of the Connecticut State Hospital in Middletown on "Mental Diseases in Connecticut," by Doctor G. E. Haggart of the Lahey Clinic on "Surgical Treatment of Degenerative Arthritis."

Officers of the Waterbury Medical Association elected at the annual meeting in January are: President, John S. Dye; Vice President, Richard J. Hinchey; Secretary, H. J. Stettbacher; Treasurer, Andrew C. Swanson.

The Yale Medical Society has heard a series of excellent presentations of original studies since the first of the year. In January, Doctor Charles Armstrong of the National Institute of Health reviewed recent studies on Choriomeningitis and Poliomyelitis. In March four papers from the laboratories of the Yale School of Medicine were presented by members of the faculty as follows: Myocardial lesions due to dietary deficiency by Doctor Robert M.Thomas; The skin eruption and false-positive Wasserman in infectious mono-nucleosis by Doctor Joseph F. Sadusk; The factors controlling the electrolyte and water composition of muscles by Doctors Daniel C. Darrow, Herman Yannet and Herbert C. Miller; An experimental examination of the factors causing ureteral dilatation of pregnancy by Doctors G. van Wagenen and Ralph H. Jenkins. In April the program was: The transplantation of the vertebrate eye and return of vision by Doctor Leon S. Stone; Recovery of fatigued muscle following injection of potassium salts by Doctors Paul K. Smith, Alexander W. Winkler and Hebbel E. Hoff; Clinical interpretations of blood iodine values by Doctors Douglas S. Riggs, Edwin F. Gildea and Evelyn B. Man; The repair of tracheal and bronchial defects with free fascia grafts — an experimental study — by Doctor Max Taffel.

The eighth annual meeting of the Harvey Cushing Society was held at the Yale School of Medicine April 6-8 celebrating Doctor Cushing's seventieth birthday. Scientific papers and demonstrations were presented at the various sessions. The annual dinner was held at the New Haven Lawn Club on April 8th with the Presidential Address given by Doctor Louise Eisenhardt.

The Visiting Nurse Association of New Haven has issued a small four page leaflet describing briefly and informatively its organization and function, how one gets the help of a Visiting Nurse, what the nurse does and what the cost of the various services is to the "consumer."

Officers of the New Haven Medical Association for 1940, elected at the Annual Meeting in January are: President, Axel P. Bergman; Vice President, Maurice J. Strauss; Recording Secretary, John C. Mendillo; Financial Secretary, Ralph W. Nichols; Treasurer, Charles E. Sanford; Executive Committee, Robert G. Tracy and John F. Sullivan; House Committee, Courtney C. Bishop and A. Lewis Shure; Literary Committee, Benedict R. Harris and Finance Committee, Thomas J. Sullivan.

The following new members were elected: John A. Chasnoff, Long Island Medical College, 1936; Mario G. Conte, University of Naples, 1935; Jachin B. Davis, University of Kansas, 1933; Samuel J. Goldberg, Jr., Harvard, 1936; Charles H. Hodgkins, Jr., Hahnemann Medical College, 1936; Wilbur D. Johnston, Yale, 1937; Gerald Klatskin, Cornell, 1933; Thomas E. Shaffer, Cornell, 1932; *Non-Resident*: Dominic D'Anbruosi, Columbia, 1936; Samuel M. Dreher, Temple, 1937; Donald T. Hughson, Yale, 1927.

The quality of scientific papers presented to the New Haven Medical Association at its fortnightly meetings continues to be of high order. In February, Doctor John Russell Twiss, assistant clinical professor of Medicine, New York Post-Graduate Medical School, Columbia, gave a practical review of the "Medical Management of Disorders of the Biliary Tract" and Doctor Stewart H. Clifford of the Boston Lying-In-Hospital discussed the "Premature Infant." At this latter meeting Doctor William C. Duffy of New Haven presented an interesting report on "Impalpable Goitre with Respiratory Obstruction." In March, Doctor Henry H. Foxon, attending physician, Massachusetts General Hospital, discussed "The Management of Peripheral Vascular Disease" and Doctor Harold George Wolff, assistant professor of medicine, Cornell University Medical College, associate attending physician in charge of Neurology, New York Hospital, presented a paper on "Medical Treatment of Pain."

The Journal of the A.M.A. for March 30, 1940, contains a paper on "A Hospital Epidemic of Flexner Dysentery caused by Contaminated Ice." The authors are E. J. Godfrey M.D., M.P.H., Waterbury, and M. A. Pond, M.P.H. New Haven.

"Omentumectomy As a Safeguard Against the Recurrence of Omental Adhesions" is the title of a paper by Doctor Charles L. Larkin and Virginia G. Burnham of Waterbury appearing in the New England Journal of Medicine, issue of February 8, 1940.

* * * *

Windham

Doctors Edward J. Ottenheimer of Willimantic and Ralph L. Gilman of Storrs are the authors of a paper entitled, "Rupture of the Retroperitoneal Duodenum," which appeared in the New England Journal of Medicine, issue of February 15, 1940.

SPECIAL NOTICES

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY — EXAMINATIONS

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Atlantic City, N.J., from Friday, June 7, through Monday, June 10, 1940, prior to the opening of the annual meeting of the American Medical Association in New York City on Wednesday, June 12, 1940. Formal notice of the exact time and place of the examination will be forwarded to each candidate several weeks in advance of the examination dates. Group A candidares will be examined on June 7 and 8, and Group B candidates on June 9 and 10.

Candidates for *re-examination* in Part II must make written application to the Secretary's Office *before April* 15.

The annual dinner of the Board will be held in New York City on Wednesday evening, June 12, 1940, at the Hotel McAlpin. Diplomates certified at the preceding days' examination will be introduced personally, and there will be several speakers. All Diplomates of the Board, and others interested in the work of the Board, are cordially invited to attend this dinner.

Tickets at $3.50 each may be obtained from Dr. Joseph L. Baer, chairman, 104 S. Michigan Avenue, Chicago, Illinois, or at the registration desk during the examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* * * *

AMERICAN ASSOCIATION OF INDUSTRIAL PHYSICIANS AND SURGEONS

The 25th Annual Meeting of The American Association of Industrial Physicians and Surgeons, together with the 1st Annual meeting of the American Industrial Hygiene Association, will be held at Hotel Pennsylvania, New York City, June 4, 5, 6, and 7, 1940. This will be a four-day Convention intensively devoted to the problems of industrial health in all of their various medical, technical, and hygienic phases, with particular stress on prevention and control of occupational hazards. Important programs have been prepared, and technical and scientific exhibits will be a feature of the Convention. The Dinner on Thursday evening, June 6, will be the occasion of the presentation of the Wm. S. Knudsen award for the year of 1939-40. The Medical profession is not only invited, but urged to attend these gatherings as they will be of unusual interest and value to all practitioners interested in industrial injuries and illnesses.

* * * *

POSTGRADUATE COURSE IN OBSTETRICS

Through the cooperation of the Illinois State Department of Public Health, the Division of Child Hygiene; and the Children's Bureau, U.S. Department of Labor, The Department of Obstetrics and Gynecology of The University of Chicago and The Chicago Lying-in Hospital is offering five to six weeks postgraduate courses in obstetrics for practitioners during the next several months.

In general, the major portion of the didactic work will be done by Dr. Melbourne W. Boynton and Dr. John H. Morton, but all of the other members of the Department of Obstetrics and Gynecology will participate in various degrees in these postgraduate courses.

Except for a deposit of $25.00 ($10.00 is returned at the completion of the course) the only expense to the individual will be that of his board and room, and his own personal incidental expenses. The enrollment for each course will be kept small to promote a direct and personal relationship between the practitioners and the staff. Detailed information will be mailed to you shortly.

The first three periods are set for April 29, 1940, to June 8, 1940, June 17, 1940 to July 20, 1940 and July 22, 1940, to August 24, 1940. Interested physicians may communicate directly by addressing: Postgraduate Course, Department of Obstetrics & Gynecology, 5848 Drexel Avenue, Chicago, Illinois.

* * * *

ATTENTION, GOLFERS!

The American Medical Golfing Association's Twenty-Sixth Annual Tournament will be held at Winged Foot Golf Club, Mamaroneck, New York, Monday, June 10, 1940. Winged Foot has two famous championship courses and a beautiful club-house.

Some 250, out of the 1,360 Fellows of the A.M.G.A., are expected to take part at Winged Foot in the 36-hole competition. Each contestant will play both courses. The hours for teeing off are from 7:00 a.m. to 2:00 p.m.

The sixty prizes, in the nine events, will be distributed after the banquet at the club-house at 7:00 p.m.

Officers of the A.M.G.A. for 1940 are George Washington Hall, M.D., Chicago, President; D. H. Houston, M.D., Seattle, First Vice-President; Grayson Carroll, M.D., St. Louis, Second Vice-President; Bill Burns, Secretary, 2020 Olds Tower, Lansing, Michigan.

The New York Golf Committee is composed of James Craig Joyner, M.D., Chairman, 718 Park Avenue, New York; Edwin G. Zabriskie, M.D., Charlton Wallace, M.D., Orrin Page Wightman, M.D., and Asa Liggett Lincoln, M.D.

All members of the A.M.A. are eligible for Fellowship in the A.M.G.A. For registration application write the Secretary.

COMING MEETINGS

May 6-9 — Medical Society of State of New York, Annual Meeting, New York City.

May 14—8:30 p.m. Fairfield County Medical Association, Pickwick Arms, Greenwich. "Modern Trends in Chemotherapy" — Francis G. Blake, New Haven.

May 14-15 — New Hampshire Medical Society, Annual Meeting, Concord, New Hampshire.

May 15—New England Pediatric Society, Massachusetts General Hospital and Longwood Towers, Boston, Mass.

May 21-22 — Massachusetts Medical Society, Annual Meeting, Boston, Massachusetts.

May 22-23 — Connecticut State Medical Society and Connecticut Hospital Association, Annual Meetings, Hotel Bond, Hartford.

June 4-6 — National Gastroenterological Association, Annual Convention, Hotel Roosevelt, New York City.

June 4-6 — Medical Society of New Jersey, Annual Meeting, Atlantic City, New Jersey.

June 5-6 — Rhode Island Medical Society, Annual Meeting, Providence, Rhode Island.

June 8-10 — American College of Chest Physicians, Annual Meeting, Biltmore Hotel, New York City.

June 23-25 — Maine Medical Association, Annual Meeting, Rangeley Lakes, Maine.

House of Delegates

Connecticut State Medical Society

Hunt Memorial Building

Hartford, Tuesday, May 21
10 a. m.

CLUB SODA
Sparkling
CANADA DRY WATER
"CANADA DRY"
PALE GINGER ALE
The Champagne of Ginger Ales
The Water with the Champagne Sparkle

YOU enjoy the full rich flavor of the world's finest ginger root in Canada Dry Ginger Ale. A grand beverage!

Sparkling Canada Dry Water is a fit companion to fine spirits. A grand mixer!

Both bring you the extra sparkle of Canada Dry's own process PIN POINT CARBONATION.

CANADA DRY
World Famous for Quality

• OBITUARIES •

ERNEST HERMAN SMITH, M.D.
1893-1939

In the death of Doctor Ernest Herman Smith on July 13, 1939, one of the old type of family physicians was lost to Redding, Conn.

Fifty years of the practice of medicine in one community had produced a relationship to the citizens of that community of medical adviser, friend, and general counselor. These years were formative years in the lives of the majority of the citizens of Redding, but it is a singular tribute to the professional ability and the personality of Doctor Smith that he was adopted on the same basis by the majority of those who sought country residence as a relief of some of the burdens of city life, Thoughtful people: artists, authors, businessman, philosophers and physicians; men and women who had found the intrinsic values in life.

The relationship of Doctor Smith to the family life of Redding may not lightly be passed over because it is a positive demonstration of the importance of the personal relations between the family and the family physician. The feeling of personal loss that has been expressed by the citizens of that town is proof that it has existed there and is a memorial of which we as members of the same profession should be proud to recognize and thankful that we have lived in an age when such service is appreciated by those we serve and that we have men in our profession who are qualified to render it.

In preparation for his profession Doctor Smith was peculiarly prepared for his field of practice: He was born in the year 1863 in West Roxbury, Mass., and after graduating at the Boston Latin School went to Amherst where in the class of '85 he was awarded his Phi Beta Kappa. He then had the benefit of teaching in the Hill Academy for a year and supplimented the finances thus secured by tutoring during his course in medicine at Columbia. He not only "worked his own way through college" but also helped his brother.

On graduating from Columbia in '89, he returned to Redding, where he had been teaching, and settled down there for practice.

The following year he married the daughter of Doctor Wakeman, who had preceeded him as the "Country Doctor" in Redding.

Thus teaching, tutoring, assembling symptoms upon which to form an opinion, peculiarly fitted him for giving considered advice to those who sought his counsel.

When the question is being raised, by some, as to the value of the relationship between patient and physician it is well for us as physicians to pause and render tribute to an instance where this idealized relationship has existed.

In reviewing a life work of 50 years by one of our profession that has really been outstanding, it is well for us to face two questions: Have social conditions changed to such an extent that our fellow men no longer need or desire such service from us? — and, secondly, Is the personnel of the profession of today qualified to render such service? Doctor Ernest Herman Smith answered both questions, for his day, in the affirmative.

D. Chester Brown, M.D.

• Quarto Notes •

THE THERAPEUTICS OF INTERNAL DISEASES — VOLUME I.

Edited by
George Blumer, M.A., M.D.
and
Albert J. Sullivan, M.D.
872 pages
New York D. Appleton-Century Co. 1940

This volume treats of the general principles of therapy under the sub-divisions of nutrition, medical climatology physiotherapy, endocrinology, therapeutic use of gases, technic of drug medication, etc., and these subjects are of necessity discussed in a rather general manner.

The section on nutrition and dietetics gives a condensed summary of the present knowledge of the chemistry and physiology of the vitamins, proteins, carbohydrates, fats and inorganic salts. An estimate of the daily requirement of each of these food essentials is made and the fundamental principles of construction of diets are outlined, but there is little specific information on therapy in this section.

Medical climatology, spa therapy and physiotherapy are very adequately treated, and the average physician, who tends to neglect these fields, will find a great many new ideas and useful methods.

The fundamentals of radiotherapy are discussed in detail, giving a complete conception of the physics of radioactivity and x-rays, and the physiological and pathological effects of the rays on the various kinds of tissue. The discussion of therapy is of necessity limited to the indications for applications of this treatment in disease, with all details left to the specialist in this field.

Probably the outstanding chapter in this volume is the one on the therapeutic use of gases. It contains an excellent discussion of the physiological basis for the use of the various gases, a detailed description of the different types of apparatus and a consideration of the conditions under which the use of each of the gases is indicated. Of especial interest are the discussions on the use of helium, of one hundred per cent oxygen and of positive pressure respiration.

The physiology of the endocrine glands is considered and some of the outstanding preparations of each hormone listed, but here again details are limited, because of the rapid development of this field and the changes thereby made necessary.

The remaining chapters, which are devoted to serum and vaccine therapy, non-specific therapy, bacteriophage and therapeutic technic are complete with standard information and will serve as an excellent source for reference on these subjects.

The volume as a whole contains a wealth of material with the information on therapeutics somewhat overshadowed by physics, chemistry and physiology.

R. E. Durkee

* * * *

THE THERAPEUTICS OF INTERNAL DISEASES — VOLUME II

Edited by
George Blumer, M.A., M.D.
and
Albert J. Sullivan, M.D.
1042 pages
New York D. Appleton-Century Co,, Inc. 1940

In reviewing this volume it becomes necessary to review in reality two complete books: one a textbook of pharmacology and toxicology 458 pages in length; the other, a 511 page book on the therapy of infectious diseases. The authors of the various chapters are all renowned in their respective fields, so that the result is an authoritative encyclopedia of therapy.

The first section is an excellent, practical treatise on pharmacology, discussing from the point of view of the practitioner the general problems of medication as well as the specific drugs available to him. These drugs are grouped according to the nature and site of their actions. The discussion is not only exceedingly practical, but also embodies the most recent discoveries. A number of drugs, moreover, that have been carried along through the years more by the weight of tradition than by their actual merits are mentioned as being notable, chiefly from the fact that they would not be missed if omitted entirely from the pharmacopea. Strychnine, camphor and amidopyrine are examples. In contrast to these there is information on the latest advances in chemotherapy. The uses of sulphanilamide and sulphapyridine, for instance, are carefully described and their dangers pointed out. Even the recently reported peculiar toxic reaction of dilantin on the gums is mentioned, although its use is not as widely known as that of more spectacular chemotherapeutic agents.

The concluding 100 pages of this first section are devoted to toxicology. Here is described not only the treatment of the common poisonings, but also the toxicology of the drugs whose actions and uses were discussed in the previous pages.

A chapter on the general management of the sick with a discussion of their care during convalescense serves as a transition from the account of therapeutic agents to the series of articles on the specific therapy of infectious diseases.

Recent advances in chemotherapy and serum treatment are making the therapy of infectious diseases a continually progressing science. This is brought out in the final section which deals with the modern treatment of the various infectious diseases. Chemotherapy of pneumonia — perhaps the most spectacular advance in specific therapy during the past few years — is completely described, and its relation to the use of serum is discussed. Treatment of many lesser known infectious diseases is presented, as well as a thorough discussion of the management of the more common infections. The treatment of syphilis alone occupies 130 pages in which the conclusions of the Cooperative Group are outlained and every conceivable problem in the handling of this comprehensive disease is presented.

A good bibliography in each section and a detailed index make this large volume as handy and easy to use as would be the several small volumes that actually compose it. Because of its practicalness, completeness and up-to-dateness this volume will be of value to all practicing physicians.

W. F. Smith

* * * *

PNEUMOCONIOSIS (Silicosis)

THE STORY OF DUSTY LUNGS

A Preliminary Report by Lewis Gregory Cole, M.D.
Director of Silicotic Research,
John B. Pierce Foundation, New York City,
and
William Gregory Cole, M.D., New York City
113 pages, 26 figures, with an appendage of two previous reprints by the Authors. $1.00
New York City John B. Pierce Foundation 1940

The work is based on the pathological and x-ray material of 200 cases diagnosed as silicosis, lent to the authors by earlier investigators.

A registry of these cases, similar to the Sarcoma Registry of Codman, has been set up. It is hoped that this Registry will be a clearing house for future pneumoconiosis material and a place of reference for interested workers in the field.

It gives a history of the disease, its etiology, pathogenesis, four types, roentgenology and the social and economic aspects.

The outstanding revelation of the study is the unrecognized serious disability with minimal x-ray evidence of acute silicosis and the extensive roentgenologic findings without symptoms of pneumoconiosis.

J. A. Wentworth

* * * *

CARDIOVASCULAR — RENAL DISEASE

by

Lawrence W. Smith, M.D., Professor of Pathology
Edward Weiss, M.D., Professor of Clinical Medicine
Walter I. Lillie, M.D., Professor of Ophthalmology
Frank W. Konzelmann, M.D., Professor of Clinical Pathology
Edwin S. Gault, M.D., Assoc. Professor of Pathology
Temple University School of Medicine

227 pages $4.50
New York D. Appleton-Century Co. 1940

Only at infrequent intervals is there offered to the medical profession such a helpful collection of material as may be found in this volume which correlates all the information available on cardiovascular — renal disease. For years a confusing subject to the medical student, the previous knowledge of it has been no less unsatisfactory to both clinician and pathologist.

The prevalent general concept regarding essential hypertension is clearly presented in this volume and along with this is a clear explanation of the renal reaction to this process, nephrosclerosis, and of the effects on heart, brain and extremities. The book particularly emphasizes the importance of ophthalmoscopy in diagnosis, prognosis and treatment and to this end affords a generous number of plates showing ophthalmological lesions. The pathological data throughout the volume is convincing and here also many cuts are supplied to illustrate the various lesions. To the Metropolitan Life Insurance Company goes the credit for the valuable statistical data used as a framework for the discussion.

As one carefully reviews the material found between the covers of this book one is compelled to make mental note of the vast change which has developed in the concept of cardiovascular — renal disease during recent years. This is particularly striking in the relationship to coronary disease, in the clearer re-classification of the various types of kidney diseases, and in the sequelae of eclampsia.

The volume includes many case histories, illustrative of different types and forms of cardiovascular-renal disease; an appendix containing tables and charts summarizing much of the material in the book; and an excellent bibliography covering eighteen pages. There is scarcely a physician practicing any branch of medicine who will not find this book of considerable interest and of inestimable value as a reference.

* * * *

DISEASES OF THE GALL BLADDER and BILE DUCTS

by

Waltman Walters, B.S., M.D., M.S., So.D., F.A.C.S.,
Head of Sec. in Division of Surgery, The Mayo Clinic;
and
Albert M. Snell, B.S., M.D., M.S., F.A.C.P.,
Head of Sec. in Division of Medicine, The Mayo Clinic

645 pages 342 illustrations $10.00
Philadelphia W. B. Saunders Co. 1940

This book is written from a background of almost unbelievable experience on the part of the authors, Doctor Walters from the surgical department and Doctor Snell from the medical department of the Mayo Clinic. Supporting the authors is a staff of 7 of their colleagues, all outstanding men, who contribute 9 of the 33 chapters. An appendix on operating room technic is contributed by Sister Mary William of St. Mary's Hospital.

The text is divided into 5 parts under the following headings: 1. Anatomy, Physiology and Pathology; 2. Diseases of the Gallbladder; 3. Diseases of the Bile Ducts; 4. Medical and Surgical Treatment; and 5. Preoperative and Postoperative Care.

The extent of the material which forms the basis of the book is realized when one reads on page 79 that 29,701 gallbladders have been surgically removed at the Mayo Clinic between the years 1893 and 1937. This is an average of 660 yearly, a figure which allows the authors to draw instructive and pertinent conclusions. Particularly timely are the sections on the bleeding tendency in jaundice and the use of vitamin K and bile salts in the treatment of this hemorrhagic diathesis.

The foreword to the book was written by Doctor William J. Mayo and probably represents one of the last of his writings. The style, language, form and print make it easy to read and difficult to put aside. The editing was in charge of Doctor Richard M. Hewitt, who, incidentally, is a native of Connecticut, having been born in New London.

The book is well balanced in the distribution of the material and any physician, general practitioner or specialist, whose field touches in any way the diseases of the gallbladder and bile ducts would do well to add this first edition to his library.

C. J. McCormack

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

INJECTION TREATMENT
of
HERNIA, HYDROCELE, GANGLION, HEMORRHOIDS, PROSTRATE GLAND, ANGIOMA, VARICOCELE, VARICOSE VEINS, BURSAE, AND JOINTS
by

Penn Riddle, B.S., M.D., F.A.C.S., Assistant Professor of Clinical and Operative Surgery, Baylor University, College of Medicine

290 pages 153 illustrations $5.50
Philadelphia W. B. Saunders Co. 1940

This is a book written by one who has had a great deal of experience with injection treatment of various conditions as indicated by the title. Dr. Riddle, in our opinion, has attempted to be fair in evaluating the various results of such treatment. Undoubtedly, he is an enthusiast and even being aware of this, one cannot be carried away by the results, particularly concerning hernia, and Dr. Riddle's own figures are not too brilliant. A word of caution should be made here so that the casual reader may not think that this treatment is going to supersede surgery and it should be emphasized that rigid attention to detail and directions such as are set forth in this book must be followed, else dire results may and will easily follow promiscuous use of injection treatment. Certain figures in the book are rather misleading and do not support the contentions of the author; for example, he states that the mortality for a group of 2,436 patients with hernia who were operated on, excluding death through strangulation, was 0.48% and that others have reported the cases of several thousand patients treated by the injection method without a single fatality but they have "reported fatalities in cases in which patients received the initial treatment elsewhere." His figures for the results of injection for inguinal hernia in 117 patients are not too persuasive; for example, the cures in patients followed from six to eighteen months is given as 60%, whereas the actual number listed as cured are only 33. We cannot accept 60% as the percentage of cure in injection treatment. There are many illustrations and diagrams which in general are very good but for some we could find no special reason; for example, there is pictured a patient with a large post-operative incisional hernia before and after operation and the picture "after operation" shows the patient with a belt on.

With the heralding of the success of this book by the publisher on the front page of a recent issue of the American Medical Association Journal, let it be understood that we feel that there will be a great increase in the use of injection treatment for various conditions. The unwary will probably extend these methods of treatment in their practices to the economic and physical detriment of many patients in many cases unless careful selection is made. The volume is most valuable for its historical reviews and for the descriptions and illustrations of technical procedures.

B. B. Landry

CONSULT WI' A SIP!

One sip o' Johnnie Walker wi' soda will convince ye that all's well wi' this grand whisky. Aye, it will tell ye that there's no finer whisky than Scotch... and Johnnie Walker is Scotch at its smooth, mellow best!

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820...
still going strong

Canada Dry Ginger Ale, Inc., New York, N.Y., *Sole Importers*

SILVER PICRATE

Wyeth

HAS SHOWN A CONVINCING RECORD* OF EFFECTIVENESS IN ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae • Trichomonas vaginalis
Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

ABSTRACT

The Vitamin B Complex and Its Constituents in Functional Digestive Disturbances

Chesley, F. F., Dunbar, J., and Crandall, L. A., Jr.,
Am. J. Dig. Dis. 7: 24-27 (Jan.), 1940

The whole natural unfortified vitamin B complex appears to offer practical relief for many gastro-intestinal complaints that are not of an organic nature, according to a clinical investigation conducted on 44 patients with functional digestive disturbances at Northwestern University Medical School, Chicago.

Gastro-intestinal symptoms for which the patients were treated over an extended period of time were anorexia, flatulence, abdominal distress, alternating constipation and diarrhea, constipation only, diarrhea only, and skeletal pain.

The whole vitamin B complex was much more effective than any of its components, for example, vitamin B (thiamin) or vitamin B (riboflavin) or nicotinic acid, in relieving gastro-intestinal disturbances. In fact, thiamin and riboflavin gave practically no relief; nicotinic acid, while helpful, was not as effective as the whole B complex.

The investigators determined, as nearly as they were able, the degree of B-avitaminosis among their patients. They did this through biological assays on the urinary excretion of thiamin. In many of the cases where the urinary excretion of thiamin indicated a deficiency of vitamin B, excellent therapeutic results in the treatment of the above gastro-intestinal malfunctions were secured through vitamin B therapy.

The investigators used a vitamin B complex concentrate derived from brewers' yeast that contained all the factors of the vitamin B complex in proportion as found in the brewers' yeast.

☆☆

ARITHMETIC PROBLEM

If the average case of minimal tuberculosis admitted to the sanatorium stays 8 months, and the average case of moderately advanced tuberculosis stays 23 months, how much could be saved by early diagnosis?

In Connecticut where it costs about $1,000 to keep a patient in the state sanatorium for a year and where only 10% of the admissions are in the minimal stage, it is estimated as hundreds of thousands of dollars by the Connecticut State Tuberculosis Commission.

Unfortunately, the situation in Connecticut is not unique among the states. Everywhere admissions to sanatoria are largely in the later stages, and everywhere the result is a longer hospital stay — a tragic waste whether human suffering, disability or money is considered.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1940-1941) 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) 5

MESSAGE FROM THE PRESIDENT OF THE CONNECTICUT STATE MEDICAL SOCIETY
Arthur B. Landry, M.D., Hartford, Conn. 313

ORIGINAL PAPERS:

Trichinosis — . . . George Blumer, M.D., New Haven, Conn. 314
American Medical Association — New Haven—1860 — Creighton Barker, M.D., New Haven, Conn. 319
American Federation of Labor and Health Insurance — Robert J. Watt, Washington, D.C. 322
Obstetric Aspects of Prematurity — . . Emerson L. Stone, M.D., New Haven, Conn. 326
Digitalis U.S.P. XI — . . . Arthur J. Geiger, M.D., New Haven, Conn. 331
Treatment of Gonococcal Salpingitis and Arthritis with Sulphanilamide — Robert M. Lewis, M.D., New Haven, Conn. 335
Pneumo-Myelography in Diagnosis of Spinal Cord Lesions — Bernard S. Brody, M.D., New Haven, Conn. 337

ASSOCIATION OF CONNECTICUT TUMOR CLINICS:

Sixteenth Meeting of the Association, Meriden, March 7, 1940 — 338

CONNECTICUT STATE DEPARTMENT OF HEALTH:

Efficiency of Serological Tests for Syphilis in Connecticut
F. L. Mickle, Sc.D., and E. K. Borman, M.S., Hartford, Conn. 351

EDITORIALS:

The 148th Annual Meeting 356
Dean Blake 357
The Health of Our Children 357
Treatment of Bacterial Endocarditis 358
The God of War Calls 359

FROM THE SECRETARY'S OFFICE 361

NEURO-PSYCHIATRIC INSTITUTE OF THE HARTFORD RETREAT REPORT . . 363

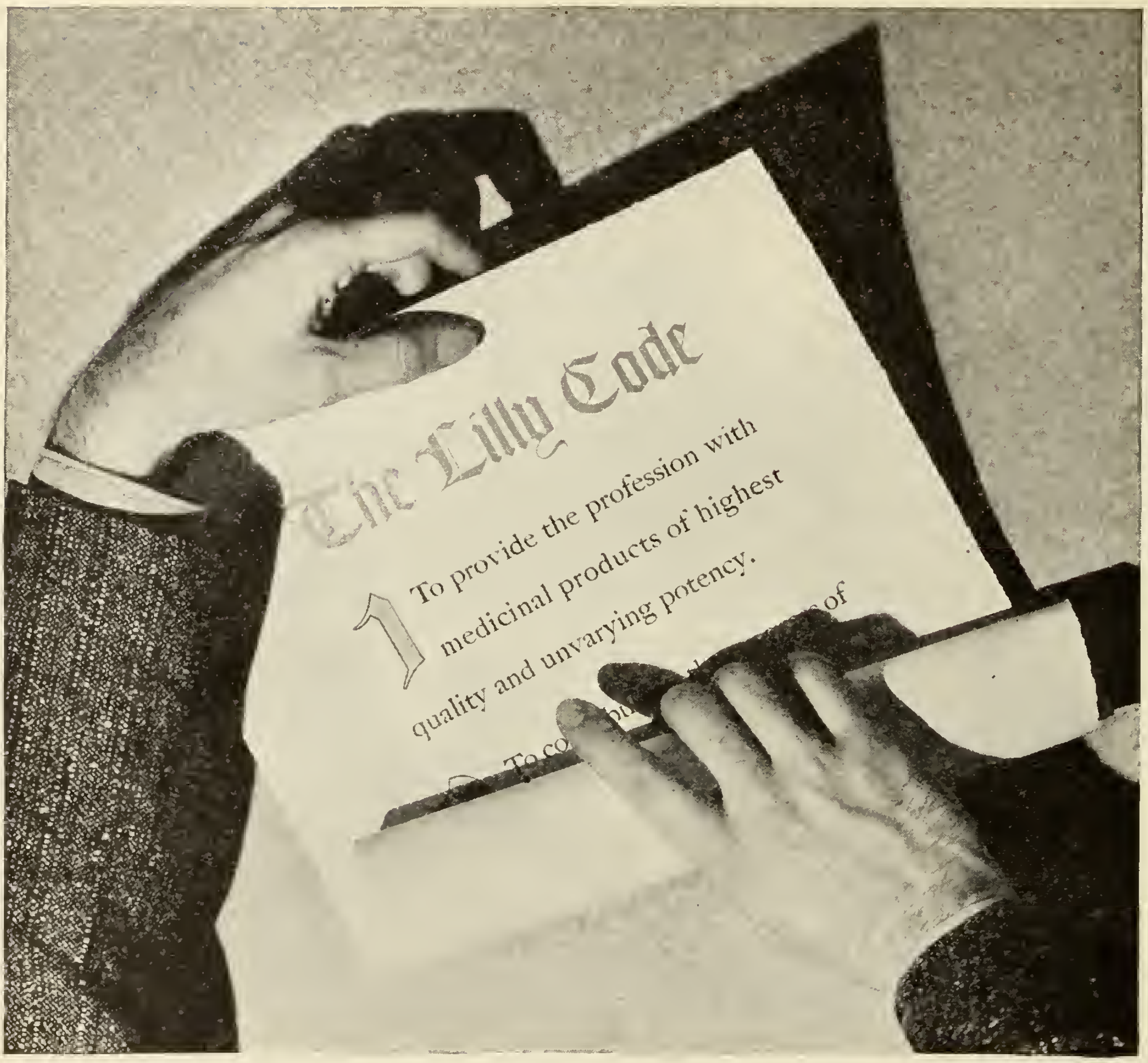
GENERAL PRACTITIONER'S FORUM 366

OUR NEIGHBORS 367

NEWS FROM COUNTY ASSOCIATIONS 367

SPECIAL NOTICES 370

QUARTO NOTES (Book Reviews) 372



The Lilly Code

1 To provide the profession with medicinal products of highest quality and unvarying potency.

To co

Orally Administered Bismuth in the Treatment of Syphilis

Pulvules Sobisminol Mass, Lilly,* in a dose of two or three pulvules three times daily, rapidly produce a high urinary bismuth excretion and exert a powerful antisyphilitic effect. To guard against inadequate treatment through irregularity of administration, Sobisminol Mass may best be regarded as an adjunct to parenteral therapy.

A convenient test kit for determination of urinary excretion of bismuth is available.

*Contains a complex organic bismuth compound resulting from the interaction of sodium bismuthate, tri-isopropanolamine, and propylene glycol.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

These are your Friends

Arthur Bernard Landry, M.D.
Born 1884
Graduate Jefferson Medical College
Fellow American College Physicians
President Hartford Medical Society

CAT.

MESSAGE FROM THE PRESIDENT

CONNECTICUT STATE MEDICAL SOCIETY

Nearly a century and a half of experience in organized medicine is our heritage today as members of the Connecticut State Medical Society. For within that span of years the aim of the Society to perpetuate the best traditions of medicine and to improve the quality of practice has been attained.

Two years hence the Society will commemorate the fullness of those years. But while planning for the Sesquicentenary we of this generation have the epilogue to complete in the long role of successive achievements. There is work ahead for us. We have yet to increase our membership to embody every qualified practitioner of medicine in the State.

While rightfully circumspect of all new formulae affecting medical practice, we are constrained by the very nature of our profession and by our place in society to labor incessantly in the interest of adequate medical care for all the people. On the other hand we must strive also to meet the challenge of any turn of circumstance that would reduce the practice of medicine from a profession to a trade. To be sure, whatever problems beset us today we are better prepared to solve them than we were five years ago, two years ago and even one year ago.

The office of the Society, recently established with a full-time personnel has but laid the foundation of invaluable service designed to be rendered to the profession and to the public. The young but robust Connecticut State Medical Journal has the unending task of disseminating better and better medical knowledge and publishing pertinent information of our activities, not only, but also has the responsibility of orientating the physician in the changing order of medical practice and indeed of society itself. With a full cooperative membership, a hard working Council, an efficient executive office, a first class Journal, progressive committees and a well informed House of Delegates, the work before us should be done well and with pleasure.

Let us all face the new year with courage and hope. May the epilogue be worthy of record with the long list of distinguished achievements in the Sesquicentennial.

ARTHUR B. LANDRY, M.D.

The Connecticut State Medical Journal

VOL. IV. JUNE, 1940 No. 6

Trichinosis

GEORGE BLUMER, M.D.,
New Haven, Conn.

Since 1921 trichinosis has been a reportable disease in the State of Connecticut, so that any available figures as to its *frequency* here have been collected since that date. In November, 1937, Dr. Knowlton, the Director of the Bureau of Preventable Diseases, informed me that from January 1st, 1921 to November 1st, 1937, 222 cases of trichinosis had been reported, the smallest number reported in any one year being 2, and the largest number being 29. Thus an average of about 13 cases of trichinosis a year are reported by the physicians of this State.

In the last few years there have been a number of attempts to determine the *prevalence and distribution* of trichinosis in the United States. There are articles on this subject dating back nearly forty years, but the older figures are practically all of them based upon methods of examination which do not give the most accurate results, namely, the microscopic study of small fragments of fresh muscle, either compressed between glass plates or teased or sectioned and stained. In recent years a new technic of examination has been perfected which is usually referred to as the digestion-Baerman method. In this method a weighed quantity of muscle is finely ground up and digested at body temperature in artificial gastric juice, and the resulting fluid is centrifuged and examined under the microscope for living trichinae. As a matter of fact a combination of the two methods gives the most accurate results, because if the digestion method alone is used dead and calcified trichinae are not discovered. Recent figures covering 3,129 examinations made by a number of different observers showed that trichinae were present in 499 of these, which is a little under 16 per cent. The older figures showed only 2.3 per cent of infestation and the difference is so great that we must conclude that it cannot be explained solely by the introduction of the new method and that the disease must have been increasing in the present century.

There is very good evidence that the prevalence of the disease is quite different in the industrial and thickly-populated East, as contrasted with the rural and thinly-inhabited South and Middle West. A much larger number of cases per one thousand of population are reported in the North Atlantic states than elsewhere. There is very little doubt that the explanation of this lies in the different methods of feeding hogs which prevail in different sections of the country. In the older articles on trichinosis considerable stress was placed upon the role of the rat as an intermediate host, and a good deal was said about hogs eating rats and farmers feeding rats to hogs. While there is no doubt that the rat is frequently trichinous and is occasionally an intermediate host, there is also very little doubt that its role in the dissemination of trichinosis has been grossly exaggerated. The main reason for the greater prevalence of trichinosis in the North Atlantic states lies in the fact that in the thicky-settled portions of the country it is customary for farmers to feed uncooked garbage to their hogs, and this garbage frequently contains pieces of infected and infective pork.

In the Middle West and in the Southern states hogs are usually allowed to roam at large and are grain-fed rather than garbage-fed.

If we assume that 15 per cent of the population are infested with trichinellae then trichinosis should be a very common disease. This would mean that in the State of Connecticut, approximately a quarter of a million people are infested with trichinellae. Of course some of these would be infestations of many years standing, while others would represent comparatively recent infestations. If these figures are even approximately correct, it at once becomes pretty obvious that *there must be a great many people infested with trichinellae who have never presented the clinical picture of trichinosis.* This is one of the most important pieces of information regarding the disease that has been brought out in recent years. Anyone who has seen family outbreaks of the disease has realized, no doubt, that inapparent infestations exist. The writer has examined, on several occasions, the blood of entire families among whose members cases of clinical trichinosis had appeared, and has been able to demonstrate that the members of the family who were apparently not infected and were presumed to be well nevertheless showed definite eosinophilia, which may properly be considered as good evidence of infestation. We need more accurate information as to the proportion of individuals who become infested with trichinella spiralis and who fail to show any clinical evidences of the disease. One may guess, I think, that a considerable proportion of the individuals who consume pork infested with viable trichinellae never show any clinical evidence of trichinosis.

There are certain points about the *pathology* of the disease which are important, not because they are new but because the spectacular lesions in the voluntary muscles have been unduly emphasized at the expense of the less spectacular but frequently equally important changes in other parts of the body. It is well to bear in mind that during the period when the embryo trichinellae are invading the body they are undoubtedly carried to all the tissues and organs. They have been found in the circulating blood during life by Janeway and Herrick. They have been found in the spinal fluid by VanCott and Linz. The really important question is whether in their passage through various organs the trichinellae cause local damage, and, if so, how frequently and to what extent? It is quite certain that they may cause definite and sometimes permanent damage to the heat muscle, although they do not encapsulate there. It is quite certain that they may cause damage to the central nervous system and it is also certain that they occasionally damage the kidneys and that they probably do damage to the lungs, because pulmonary complications are quite common in the disease. It would be rather surprising if the embryo trichinellae, which are about ten times the size of the largest known bacterium and which contain toxines, did not inflict both chemical and mechanical damage.

It is not profitable in a contribution of this sort to discuss in detail the life history and structure of the parasite, *trichinella spiralis*, which causes the disease. It is, however, important to know some of the details because of their bearing on the clinical history of trichinosis. The parasite as it occurs in pork, and pork is commonly responsible for the disease, is in a larval or *sexually immature* form and is surrounded by a fibrous or fibro-calcareous capsule. When the infested pork is taken into the stomach the digestive juices dissolve the capsules and set free these larval trichinellae. A period of from 24 to 48 hours is necessary for their development into adults and for the impregnation of the female by the male parasites. This occurs in the upper part of the small intestine. After impregnation the males are said to die as a rule and the females penetrate into the lymphatics of the intestinal mucosa, into which they discharge their living and active embryos after a period of about eight days. The embryos are then carried to the neighboring lymph nodes and to the lymphatic duct and thence into the general circulation by way of the suvclavian vein. If one bears these facts in mind it becomes clear that in patients showing clinical evidences of infestation these may be grouped into three stages: (1) the stage of *ingestion*, that is to say, the period during which the parasites are maturing and the young are being formed in the small intestine, (2) the period of *invasion* of the body by the embryos, and (3) the period of *encapsulation*, during which the parasites are becoming encysted in the *voluntary* muscles.

The *clinical course* of the disease varies in different patients. Many patients present no symptoms during the stage of ingestion but some show evidences of gastroenteritis beginning a few hours after the pork has been eaten. These patients most likely vomit or they may have abdominal cramps and diarrhea with fever. Occasionally constipation rather than diarrhea occurs. Why some patients present these early gastroenteric symptoms while others do not is not clearly evident. It may be a matter of dosage and it may be a matter of individual differences in susceptibility to the action of the toxin which is produced by the parasite.

In a considerable number of patients with clinical trichinosis no symptoms appear until the period of invasion, during which the embryos escape from the intestinal lymphatics and get into the general circulation, and this of course does not occur until about seven or eight days after the infested meat is eaten, and sometimes not until as long as fourteen days after this event. At this time fever and its usual accompanying symptoms, headache, back and limb aches, etc., appears and the degree and duration of this fever varies very considerably in different patients. Sometimes only a brief attack lasting a few days occurs while in other patients the fever may persist for three or four weeks or even longer, and may be accompanied by evidence of severe toxemia. The embryos, as they are distributed through the body, undoubtedly do a certain amount of damage to the tissues and organs, although in the average case they apparently do not harm the vital organs to any great extent. They do not encyst anywhere except in the voluntary muscles, so that while they may be temporarily present in the heart muscle, the kidney, the lungs, or the central nervous system, and may do some damage to those tissues, they eventually collect in the voluntary muscles, particularly near the tendons, because the tendons are dense enough to prevent invasion and consequently hold them back. There are certain phenomena which occur during this stage which are probably due to a combination of parasitic embolism and toxemia. The most striking and common of these is edema of the eyelids, but hemorrhages underneath the ocular conjunctivae and splinter hemorrhages under the nails may also occur. The invasion of the muscles results in variable degrees of myositis with pain and disability. In some patients it is necessary to examine the muscles carefully to find any tenderness while in others the pain may be so intense that the muscles are held rigid. The myositis may be so extensive that there is inflammatory edema of the subcutaneous tissue overlying the involved muscles.

Physical examination of a patient with moderately severe trichinosis usually shows the ordinary appearance of acute infection. The face is flushed and the eyes are bright. Edema of the eyelids may be variable in degree, it may result in completely closing the eyes and often extends on to the face. The examination of the lungs often shows signs of bronchitis, and not infrequently bronchopneumonia, especially in the severer cases. The pulse is usually rapid and the heart sounds of good quality. There may be certain amount of abdominal distention, although this is not usually very marked. There are occasionally pink papules on the chest or abdomen which closely resemble rose spots.

The examination of the blood is the only *laboratory procedure* of major value in these patients. There is generally a leukocytosis, which is roughly parallel to the severity of the case, and in most patients there is a very decided increase in the percentage of eosinophilic cells. However, eosinophilia may not be marked at all times, so that frequent examinations of the blood may be necessary, and the degree of eosinophilia is no indication of the severity of the infection. Eosinophilia may be absent in very mild or in fatal attacks and the highest eosinophile ratios are apt to occur in connection with mild rather than severe attacks.

There are certain *unusual types* of clinical pictures which differ from the ordinary type and which are comparatively rare. Occasionally hemiplegia or other signs of gross damage to the central nervous system is a striking feature. Patients have been described who presented a picture of encephalitis or one resembling peripheral neuritis. There are occasionally patients in whom the cardiac damage is sufficient to produce electrocardiographic changes and in whom clinical evidence of severe cardiac involvement dominates the picture, and there are rare patients in whom evidence of damage to the kidneys is outstanding.

The *diagnosis* is not usually difficult if one has the disease in mind. Occasionally patients consult a specialist first because swelling of the eyelids leads to a suspicion of *sinusitis*, or because chemosis, which is quite common, may lead the patient to consult an ophthalmologist rather than a general practitioner. The disease which is most commonly diagnosed in the early stages of trichinosis is *typhoid fever*, but edema of the eyelids is not a feature of typhoid fever and the blood picture is entirely different; there is, of course, no Widal reaction in trichinosis. Some patients in the early stage are diagnosed as having *influenza*, but here again the blood picture is entirely different. The only disease that at all closely resembles trichinosis is the so-called pseudo-trichinosis or *dermatomyositis*, but in this disease there is usually a preliminary erythema involving the face, the edema is confined to the neighborhood of the inflamed muscles, which are apt to be those of the extremities, and there is no eosinophilia.

The *prognosis* of trichinosis in the United States is generally good. The mortality rarely reaches 5 per cent and the tremendous mortality which characterized some of the great German epidemics of the nineteenth century has never been seen in this country.

The *treatment* of the disease is symptomatic. Further experience may show that the use of convalescent serum is of value; so for, its use has been too limited to decide. It is very doubtful indeed that remedies designed to destroy the trichinae are of any value, — in fact it seems likely that they may do harm. The parasites cannot be excreted and the writer has always felt that the wholesale destruction of the embryos, which number up into the millions in a given case, might well lead to a tremendous and possibly fatal toxemia. Generally speaking, the disease has to be treated very much like typhoid fever, and especially in the more prolonged cases, special attention must be given to the prevention of dehydration and to the maintenance of adequate nutrition.

There are certain important points in the *prevention* of the disease, some of which have already been foreshadowed in the discussion of its distribution. In the last analysis the responsible person in the prevention of trichinosis is *the consumer*. If everyone thoroughly cooked pork before they ate it there would be no trichinosis, and it is evident that education of the public regarding the dangers of improperly cooked pork is of paramount importance. If the farmers who raise hogs could be educated regarding the dangers of uncooked garbage and could be persuaded to cook all garbage before feeding it to their pigs, this also would lead to a great reduction in the prevalence of the disease. It has been clearly shown that microscopic inspection of pork is not only inefficient but expensive and that it leads to the development of an unwarranted sense of security among the public. For these reasons it has been abandoned in most civilized countries.

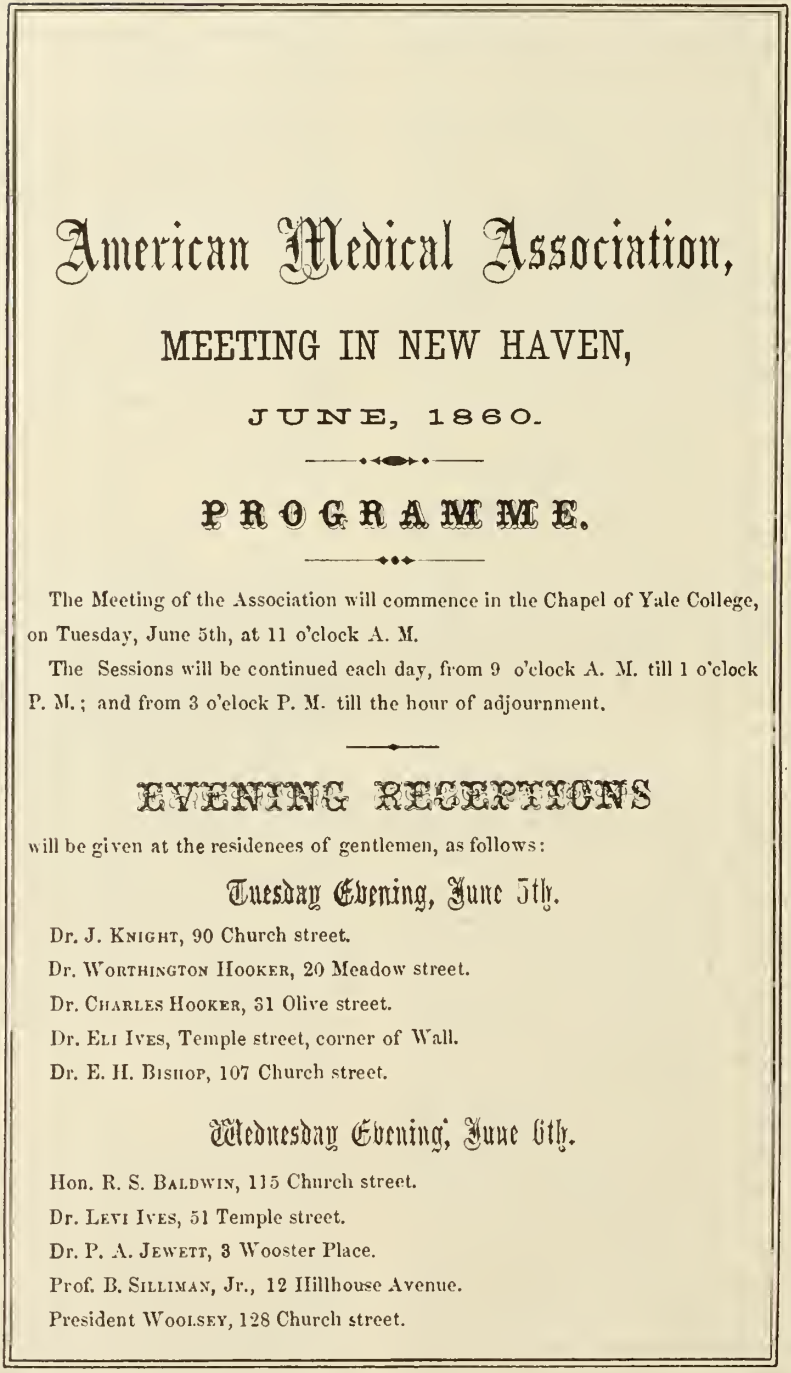
☆☆

BRAIN INJURIES

The Great War and the ubiquitous motor car have revolutionized our outlook on head injuries, so that for the past two decades less attention has been paid to fractures of the skull and more to damage of the intra-cranial contents. Indeed, in a series of 441 cases of head injury, Maclure and Crawford found 39% of them to be free from fracture of the skull. Except in cases of compound fractures, penetrating gunshot wounds, that rare form of extradural hemorrhage due to injury of the middle meningeal vessels, and, less urgently, in cases of depressed fracture causing irritation, the modern trend is towards non-interference; and, whilst combating the risks of sepsis, the surgeon tries to assess the cerebral damage.

Trotter has observed that "kinetic energy (on which the seriousness of accidents obviously depends) varies with the mass and the square of the velocity of the moving bodies concerned." Thus if an accident occurs in horse traffic moving at 10 miles per hour, and a motor accident occurs when moving at 30 miles per hour, the kinetic energy involved in the latter case is not three, but nine times that of the former. The same law applies to the bullets of war-time and the blasts of mines and high explosive missiles.

Proc. Roy. Soc. Med.
Nov. 1939



American Medical Association,

MEETING IN NEW HAVEN,

JUNE, 1860.

PROGRAMME.

The Meeting of the Association will commence in the Chapel of Yale College, on Tuesday, June 5th, at 11 o'clock A. M.

The Sessions will be continued each day, from 9 o'clock A. M. till 1 o'clock P. M.; and from 3 o'clock P. M. till the hour of adjournment.

EVENING RECEPTIONS

will be given at the residences of gentlemen, as follows:

Tuesday Evening, June 5th.

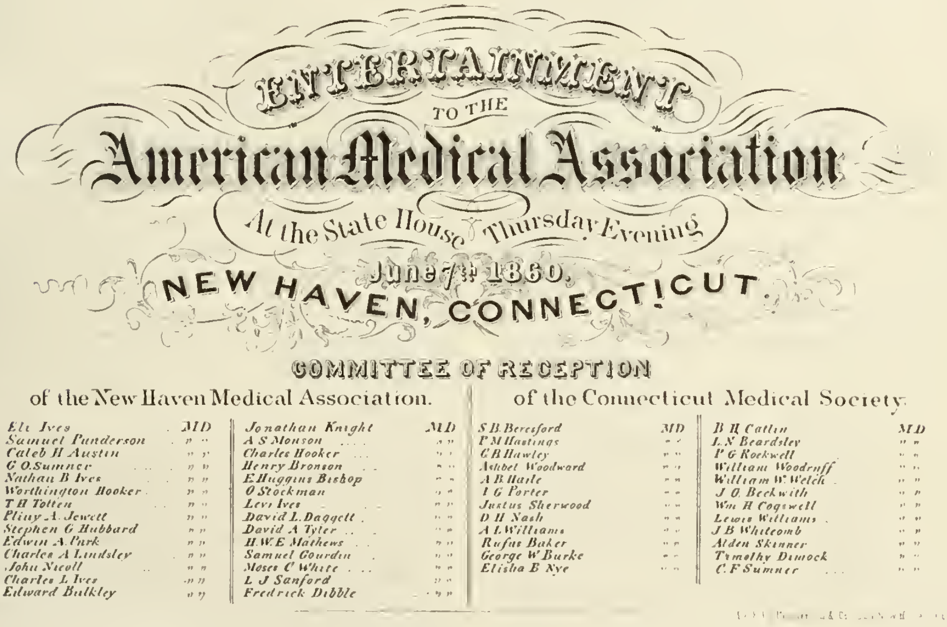
Dr. J. Knight, 90 Church street.
Dr. Worthington Hooker, 20 Meadow street.
Dr. Charles Hooker, 31 Olive street.
Dr. Eli Ives, Temple street, corner of Wall.
Dr. E. H. Bishop, 107 Church street.

Wednesday Evening, June 6th.

Hon. R. S. Baldwin, 115 Church street.
Dr. Levi Ives, 51 Temple street.
Dr. P. A. Jewett, 3 Wooster Place.
Prof. B. Silliman, Jr., 12 Hillhouse Avenue.
President Woolsey, 128 Church street.

The American Medical Association
New Haven
1860

CREIGHTON BARKER, M.D.,
New Haven, Conn.



ENTERTAINMENT
TO THE
American Medical Association
At the State House Thursday Evening
June 7th 1860,
NEW HAVEN, CONNECTICUT.

COMMITTEE OF RECEPTION

of the New Haven Medical Association.

Eli Ives	M D	Jonathan Knight	M D
Samuel Punderson	" "	A S Monson	" "
Caleb H Austin	" "	Charles Hooker	" "
G O. Sumner	" "	Henry Bronson	" "
Nathan B Ives	" "	E Huggins Bishop	" "
Worthington Hooker	" "	O Stockman	" "
T H Totten	" "	Levi Ives	" "
Pliny A. Jewett	" "	David L. Daggett	" "
Stephen G Hubbard	" "	David A Tyler	" "
Edwin A. Park	" "	H.W.E Mathews	" "
Charles A Lindsley	" "	Samuel Gourdin	" "
John Nicoll	" "	Moses C White	" "
Charles L. Ives	" "	L J Sanford	" "
Edward Bulkley	" "	Fredrick Dibble	" "

of the Connecticut Medical Society.

S B. Beresford	M D	B H Catlin	M D
P M Hastings	" "	L N Beardsley	" "
C B Hawley	" "	P G Rockwell	" "
Ashbel Woodward	" "	William Woodruff	" "
A B. Haile	" "	William W. Welch	" "
I G Porter	" "	J O. Beckwith	" "
Justus Sherwood	" "	Wm H Cogswell	" "
D H Nash	" "	Lewis Williams	" "
A L Williams	" "	J B Whitcomb	" "
Rufus Baker	" "	Alden Skinner	" "
George W Burke	" "	Timothy Dimock	" "
Elisha B Nye	" "	C. F Sumner	" "

Eighty years ago this month, in the first week of June, 1860, the American Medical Association met in New Haven. It was the 13th convention of the Association.

It is not possible to determine exactly when the proposal to bring the convention to New Haven arose nor with whom it originated, but it is not unreasonable to assume that Jonathan Knight may have been the prime mover in it. Doctor Knight was prominent in the organization of the American Medical Association in 1847 and maintained an active interest in its affairs for many years.

The first recorded reference to having the convention in New Haven is in the minutes of the annual meeting of the Connecticut State Medical Society held in Hartford on May 27, 1857. At that time Josiah G. Beckwith of Litchfield presented a resolution "that whenever the physicians of New Haven deem it expedient to invite the American Medical Association to meet in that city, the State Medical Society will join in the invitation." There is no note of any discussion of the subject during the annual meeting of the Society in Waterbury in May, 1858. At that meeting Doctor H. A. Grant, Doctor J. R. Lewis, Doctor A. B. Haile and Doctor F. S. Dickinson were named delegates from the Connecticut State Society to the American Medical Association.

The 12th convention of the American Medical Association was held in May 1859, in Louisville, Kentucky, and the records of that meeting do not show that any Connecticut delegates attended. However, it is recorded that a "pressing invitation had been received from the Connecticut State Medical Society to have the convention of 1860 held in New Haven." When the Louisville convention adjourned on May 9, 1859 it was to "convene in the City of New Haven on the first Tuesday of June 1860."

In 1859 the annual meeting of the Connecticut State Medical Society was held in Middletown on May 25 and 26, just after the adjournment of the Louisville convention, and Jonathan Knight reported to the Society that its invitation to have the 1860 meeting in New Haven had been accepted.

The move to bring the National Convention to New Haven seems at first to have been a joint enterprise of the State Medical Society and the New Haven Medical Association. Then, for some reason, the local New Haven group wanted the date changed to 1861. This is disclosed in the manuscript records of the New Haven Medical Association.

April 11, 1859, meeting at the house of Doctor Jewett.

"Notice is given that the question of inviting the National Medical Convention to meet in New Haven would be brought at the next meeting. The clerk was directed to notify members not present that the subject will be considered at the next meeting."

April 25, 1859, meeting at the house of Doctor Daggett.

"The subject of inviting the National Medical Convention to meet in New Haven was taken up. A motion was made to invite the National Medical Convention to meet in New Haven in June, 1861."

". . . . on motion a committee of three consisting of Doctors Tyler, Sumner and Knight was appointed to take the matter into consideration and ascertain what can be done towards defraying the expense of entertainment if the National Medical Convention should be invited to meet here at the time proposed."

May 9, 1859, meeting at the house of Doctor Hubbard.

"Doctor Hubbard read newspaper reports of the doings of the National Medical Convention from which it appears that that body have resolved to meet in New Haven on the first Tuesday in June, 1860, in accordance with a pressing invitation from the Medical Society of Connecticut. In consequence of the above information the committee appointed at the last meeting to inquire what funds could be raised in view of inviting the National Medical Convention to meet in New Haven in 1861 was discharged. It was further resolved that a committee be appointed to endeavor, by correspondence, to get the session of the National Medical Convention changed to some other place with the understanding that they will be invited by the City Medical Association to meet in New Haven in 1861." The committee appointed was Dr. W. Hooker, Dr. Jonathan Knight and Dr. Sumner.

Nothing came of this New Haven effort to change the date from 1860 to 1861 and at the meeting on May 23, 1859 at the house of Doctor Tyler this resolution was passed.

"The Fellows of the County Medical Society who are members of the City Association were requested to present to the State Medical Society the subject of providing for the entertainment of the National Medical Convention in 1860."

At that meeting in 1859, which was held in Middletown, after Dr. Knight had presented the report noted above, the following resolutions were unanimously adopted.

"Resolved: that we are highly gratified with the announcement that the American Medical Association is to honor our State at its annual meeting in June 1860.

"Resolved: that in accordance with the resolutions adopted by us in convention of May, 1857, we will cheerfully unite with the physicians in New Haven in giving a cordial welcome to our brethren of the National Association.

"Resolved: that for this purpose a committee of three from each County be appointed by the Fellows of the several Counties, to cooperate with the Committee on Arrangements at the City of New Haven.

(The convention then adjourned to visit the Portland quarries.)

The next day, May 26, at "7½ A.M." the convention was again called to order and the following gentlemen were appointed a Committee of Arrangements to cooperate with the Committee at New Haven, to provide for the meeting of the American Medical Association in June, 1860, viz:

Hartford County, Drs. Beresford, Hawley and Hastings.

New Haven County, Drs. B. H. Catlin, L.N. Beardsley and P.G. Rockwell.

New London County, Drs. Ashbel Woodward, A. B. Haile and L. G. Porter.

Litchfield County, Drs. Wm. Woodruff, Wm. W. Welch and J. G. Beckwith.

Fairfield County, Drs. J. Sherwood, D. H. Nash and Williams.

Middlesex County, Drs. Rufus Baker, G. W. Burke and E. B. Nye.

Tolland County, Drs. Alden Skinner, T. Dimmock and C. F. Sumner.

Windham County, Drs. Wm. H. Cogswell, Lewis Williams and J. B. Whitcomb.

The 13th annual convention of the American Medical Association opened in New Haven on June 5, 1860. The Association convened in the chapel of Yale College, and was called to order at eleven o'clock A.M. by the President, Doctor Henry Miller, of Kentucky, supported by Vice-Presidents Dr. H. F. Askew of Delaware, and L. A. Smith of New Jersey; the Secretaries, Drs. S. M. Bemiss and S. G. Hubbard with the Treasurer, Casper Wister.

Prayer was offered by the Reverend Professor Fisher, of Yale College; and Dr. Jonathan Knight, Chairman of the Committee of Reception, made an address of welcome to the Association, on behalf of the Connecticut State Medical Society, and the New Haven Medical Association.

In the afternoon Governor William A. Buckingham and Lieutenant Governor Catlin attended the convention and were given seats on the platform.

The author has in his possession a copy of the official Program for the meeting. It is a well prepared book of about 100 pages, 5¾ by 4¾, substantially bound in imitation leather and inscribed in gold on the cover "American Medical Association, New Haven, 1860." In the back of the front cover is a slip envelope in which membership cards were enclosed and also, for the official delegates, an envelope containing ten "at home" cards inviting the holder to private receptions given by the President of Yale College and prominent physicians in the city. In addition to the program of events for the convention the book includes a guide to the city "for citizens and strangers," it tells about such famous places as the Yale gymnasium, the State House, (at that time New Haven shared with Hartford the honor of being the capital of the State and the New Haven State House stood on the Green near the corner of Chapel and College Streets), the State Hospital, the orphan asylum, the alms house and the new county jail, the churches and banks. In the back of the book is a folding map of the city.

The program for the meeting included addresses on the "Medical Topography and Epidemics of the State of New York," "The Epidemics of North Carolina," "Report of Various Surgical Operations for the Relief of Defective Vision," "Report of the Improvements in the Art and Science of Surgery in the Last Fifty Years," "Report on Morbus Coxarius," "Influences of Alcoholic Drinks on the Development and Progress of Pulmonary Tuberculosis," "The Education of Imbecile and Idiotic Children." Reports of the Committee on Medical Education and the Committee on Medical Literature and the obituaries of many deceased members.

Elaborate provisions were made for the entertainment of members and their ladies. There were teas and dinners, an excursion by steam train or bus to East Rock and the ladies were especially invited to visit the shirt factory of—Messrs. Winchester & Davies.

The House of Delegates deliberated at length over problems of the day, many of which were concerned with the improvement of medical education and the elevation of professsional ethics.

During the first afternoon session officers for the coming year were nominated and the venerable Eli Ives of New Haven was elected to the presidency of the Association and escorted to the chair by Jonathan Knight of Connecticut and Dixi Crosby of New Hampshire. Doctor Ives, then 82 years old, had enjoyed an active and important career, he was a professor in Yale College for over 40 years, a botanist and horticulturist of high repute and a prosperous practitioner of medicine. His term as President of the American Medical Association was unproductive for national affairs were confused

(*Concluded on Page 365*)

The American Federation of Labor and Health Insurance

ROBERT J. WATT,*
Washington, D.C.

The disastrous consequences of illness or disability upon the economic solvency of any working man or woman were recognized and feared long before the problems of periodic unemployment or of old age dependency were recognized. Even when manufacturing was a job for the home or the small shop, the loss of income due to illness or disability was a major handicap and a source of fear among working people.

Why is it, then, that the United States has laws providing insurance to the worker of the family against the loss of wage earning power due to unemployment, old age and death?

I think the answer is as significant as it is plain. Our theory of individual ability to work hard enough and save enough to meet family needs was deeply ingrained. When the individual, for one reason or another, was unable to provide, the American people believed that relatives and neighbors could handle the burden in most cases and that the balance could be left to charity or public welfare. That theory was carried along fairly successfully while we were an agricultural community and it was carefully defended by those who wanted to avoid tax burdens. It was artificially maintained by arguments against the dangers or unconstitutionality of government operation.

The avalanche of unemployment after 1929 forcefully demonstrated the inadequacy of charity or local relief and forced the Social Security Act of 1935 on to the statute books. The depression mushroomed our existing need so suddenly and severely that the insurance program was virtually an emergency measure.

Under ordinary circumstances illness and disability are less spectacular problems for the community as a whole, because usually there is a rather constant volume of relatively isolated individual cases. Where old age dependency and unemployment were widespread mass problems, illness and disability were and are characteristically individual in their effect. Hospitals and clinics meet part of the medical problem although often the worker resorts to them too late. On the whole, individuals suffer pretty much in silence.

The American Federation of Labor is, of course, an association or fraternity of individuals. The local guilds of the Middle Ages developed fraternal plans for sick benefit payments. Characteristically these early forms of labor unions were practicising the fraternal, neighborly plan of cooperation to aid individual members. The pooling of resources against a recognized hazard faced by all but likely to strike only a few individuals at a time is the essence of social insurance.

By the test of history, therefore, the stake of labor in health insurance is demonstrated by its early action to combine group contribution for individual aid.

Under the highly competitive conditions which we find, however, there are limits to the amount of money which union members can pay out of their wages for special services from their union. If union dues are increased to provide health insurance, for example, they may prove unduly burdensome in the face of cut throat competition. However valuable such services may be, a union can seldom venture to establish adequate provisions until after it has fully organized its industry. And as you know, there are few fully organized industries even today. Anyway, I believe it is doubtful whether labor unions should seek to provide such services. With the present mobility of labor, constant changes in employment conditions, and the equal importance of family protection, health insurance would seem more a matter for the government than for the labor union.

---

*International Labor Representative, American Federation of Labor.

Social insurance, I believe, should seek the widest possible pooling of revenue and spreading of risk. If this is sound policy, the nationwide community constitutes the proper extent of coverage.

Labor unions should rather concentrate upon direct action on the economic problems arising out of the conditions of employment of their members and upon legislative sponsorship of measures to cope with the social and political questions affecting the well-being of their members.

Hence organized labor properly takes a foremost position in urging legislation to provide health insurance and disability insurance.

Let me point to what the Executive Council recommended on this subject to the 59th Annual Convention of the American Federation of Labor. I quote from the Executive Council's report as the official statement of the American Federation of Labor and I do so knowing the membership of the American Federation of Labor shares my own enthusiasm for the soundness of the following statement:

"We recommend that insurance for temporary disability be made effective in the near future to supplement workmen's compensation and unemployment compensation laws and that the federal government be urged to undertake a study of adding a program of insurance for permanent disability to the Old Age Insurance System. We recommend further that any general health insurance program be federal in scope to avoid the confusion and inequity which we have seen resulting from the varying state unemployment compensation and workmen's compensation programs.

While endorsing the principle of compulsory health insurance the Executive Council believes that the program of social insurance should be developed as a coordinated whole with due regard for the ability of low-paid groups to pay additional taxes from their pay checks. We believe that a considerable part of the program must be financed by other than pay-roll taxes since general health goes beyond the responsibility of industry. The first steps might well be the expansion of the unemployment compensation program to insure against loss of pay to persons unemployed because of temporary disability, and the placing of medical care and health services within the reach of all persons by lowering their expense. Along with these steps should go renewed efforts to find ways of increasing the economic security of the worker in jobs and the income derived therefrom. From that income the worker could then pay something toward a national program of health insurance. *We favor the principle of health insurance but urge careful planning for the program on a national basis under competent administration with a system of financing which will fit into the entire social security program before the plan is adopted. We would oppose any plan which would repeat the mistake of workmen's compensation, of allowing private-profit companies to be the insuring agents.*'

I regard that statement as a strong constructive position. I see nothing in it which would destroy the morale of our doctors or the confidence of their patients. I see nothing in it which undermines any useful institution.

On the other hand, I can think of no worse insult to the ethics of the medical profession than some of the objections set forth by the opposition.

I recall a legislative hearing in Boston on a Health Insurance bill which was filed by the Massachusetts State Federation of Labor of which I was then Secretary. The head of a state medical association appeared in opposition and told a sad tale of the awful consequences of the British health insurance system — as he interpreted them.

After listening to him, I began to wonder if doctors would lose all standards of individual decency if they were in any sense made public servants. If I believed in such a slander, I would believe that we should make haste to make them public servants and clamp a lot of rigid supervision upon them. Now we know that most doctors are not just money-grabbers, even though some of them approach that description. I know some fashionable doctors will smugly take a fat fee from an insurance company for depriving, by their testimony, some poor unfortunate cripple or his widow or orphans of the workmen's compensation due for the disabling injury or occupational disease. I know that some of these doctors have expensive offices and a fashionable practice and nobly give a proper charitable service at some clinic.

But I believe that the medical profession will achieve new heights of public service and personal unselfishness when we have a health insurance which enables a doctor to minister to those who need his aid most but who because we lack health insurance are now unable to pay his fees, secure competent nursing or hospitalization or obtain proper medicines.

I see no reason why any doctor whose conscience will let him diagnose an ailment and prescribe remedies upon which the patient's life depends should hesitate at all to accept some degree of competent supervision. The good doctor should be eager to houseclean his profession of the charlatans and he should accept any reasonable procedure to accomplish that objective.

I solemnly believe that a democracy can find a way to make its government function with a minimum of red tape for the well being of its citizens even in the field of medicine.

Why is it that the public Health Service has accomplished so much progress in the field of scientific investigation, diagnosis and treatment of disease and methods of prevention of disease? I think the answer lies in the fact that the doctor who dedicates his life to medicine really has a motive for service which is far superior to the urge of the cash register.

I have no patience with those who believe that mankind can advance only to the lure of the cash profit motive. On the contrary some of our greatest progress in every field of endeavor has come from the objective search for truth, progress and human service.

Organized labor itself endures not because of the lure of huge profits for the few but because of the unselfish devotion of the many for the well-being of their fellow workers. In fact, the profit motive is a handicap rather than an incentive.

Social insurance as exemplified in the Social Security Act was established in this country because the people recognized the inability of the individual to finance family security against unemployment, old age or death — even though a long and aggressive salesmanship had exploited commercial insurance programs to a degree which has almost created a real monoply of investment money in the hands of insurance tycoons.

After a costly experience of many years with insurance companies in the field of industrial injuries labor believes government insurance for basic minimum needs of the individual is not merely necessary for the individual worker today but is equally necessary for the community.

The sinews of democracy are found in the collective health, welfare and security of its individual citizens. Government is *for* the people if it is to have any enduring value and it must be *by* the people if it is to reflect their needs and march in step with their capacities.

I read a criticism that President Roosevelt had let the people down when he failed to push a big national health program.

I agree we need it but *I do not think we can have or should have a big national health insurance or hospitalization plan until the people know what they want and are in some degree of agreement as to how best it can be furnished.*

It is my belief that Labor must provide the leadership in informing a public opinion as to what we need and how it can best be furnished. As I think over the subject of health insurance, I am convinced that we have not yet done our part of the job.

As one individual remarked in disgust in Washington a few months ago: "Do you know any one in this city who hasn't got a health insurance plan of his own?"

That question indicates one of the major reasons why we have not yet obtained any health insurance law. There are too many people trying to father their own plans instead of putting their heads together to find the best answer and to sell that best answer to the public.

Let me stress what I believe are some essential points.

First, I would try hard to provide the maximum of service and a minimum of restrictions. Granted that there will be some chiselers, I still maintain we need to worry first of all about serving the much larger number of decent people who need medical aid with a minimum of obstacles.

Secondly, I would urge the earliest possible action in providing disability insurance to fill the gap in Old Age and Survivors Insurance.

It would be scandalous as well as heartless to make the disabled worker choose between impoverishing his family by living as against providing them with survivors' insurance by dying while his Social Security insurance is still in effect.

Personally I would, as a temporary expedient, make unemployment insurance payable to those who are unemployed because of illness. If state funds are growing too fast, I hope that the employers who hate to see this money accumulating in the Federal Treasury will be willing to promote business activity by letting workers draw their unemployment insurance when they need it most of all because they are not only unemployed but faced with extra expenses for doctors and medicine.

Finally, I would make a suggestion of my own. Why not simplify our social insurance program by insuring working people against loss of family wage income and do this by a single federal system which would pay benefits whether the loss of the weekly pay envelope is due to layoff or shut down, temporary illness or permanent disability, old age or death of the wage earner.

For elementary justice the scope of social insurance must be broadened to cover industrial accident, permanent or temporary disability injury or disease, health and a work opportunity. All such insurance should be federal in scope and simple in practice.

We have too long fattened the vultures of commercial insurance companies upon the shattered bodies of injured workmen and the misery of their poverty stricken families to tolerate any further exploitation in the foolish theory that any sins committed by insurance companies must be acts of virtue.

I see no reason for half a dozen separate systems of insurance when there is essentially the same hazard involved, namely, the inability of the family breadwinner to work at his job. And I see no reason for 51 varieties of that insurance. As an allegedly inventive and practical people, we should be able to find a way to combine a unified overhead system with the flexibility to meet local circumstances.

I suggest to the medical profession that they apply their vast fund of knowledge and experience to finding a way to hitch these plans together under an unbureaucratic federal system responsible to but not parasited with local circumstances. I am sure that the American Federation of Labor would welcome an American social insurance which provides cash for subsistence whenever the worker cannot work for wages.

—☆☆—

CHILD HEALTH CONFERENCES AS TRAINING CENTERS FOR MEDICAL STUDENTS

For some time it has been apparent that medical-school curricula have been lacking in satisfactory teaching opportunities for work with the well child, which should make up a large part of the practicing physician's work with children. The facilities for teaching pediatrics in most schools have been given over almost entirely to the care of the sick child, the medical student learning well-baby care as well as he could, incidentally, while learning the art of "healing the sick". With an increasing demand upon physicians to practice preventive medicine it seemed only logical that medical students should be given more opportunity to work with pediatricians who are supervising the health of well children.

To fill this need an arrangement has been made between the Division of Maternal and Child Health of the Department of Public Health of the City of Louisville, and the Departments of Pediatrics and Public Health of the Medical School of the University of Louisville whereby three of the child-health conferences of the City Department of Public Health are used as teaching centers for third-year medical students as part of their regular course in pediatrics.

The Child. March, 1940

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

The Obstetrical Aspects of Prematurity*

EMERSON L. STONE, M.D.,
New Haven, Conn.

Prematurity, in common with many other problems of obstetrics, is today viewed and treated in the rational and forthright manner which is characteristic of our times. A brief preliminary consideration of a few analogous but less complex factors in this evolution may serve to emphasize the point.

Some twenty years ago obstetrical teaching and practice revolved around one dominating rule of procedure, viz., "Never interfere with natural processes, for they cannot be improved upon; such interference uniformly invites trouble." As a result, the application of forceps, the induction of labor, or any alteration in the established therapeutic routine were considered grave and serious excursions into dangerous territory. A Caesarean operation always drew a large audience from many departments of the hospital, eager to witness such a daring departure from the normal. The operator was often obliged to defend his position against criticism, and was even in danger of being ranked among those who "loved to cut," who had the *furor operativa*, or whose "obstetrical resourcefulness was limited."

In our own time, any tendency toward unbridled radicalism should and must be discouraged, and no one need fear that teaching centers have departed from essentially conservative obstetrics, both in theory and practice. But twenty years ago, maternal and fetal morbidity and mortality were very high, in contrast with the prevailing figures today, and the cost in human life of maintaining this level of ultra-conservatism was tremendous.

Improvement in results has been achieved through a combination of factors, and preeminent among these is the vindication of the theories and practices of a few pioneers who dared to believe that, *under proper conditions and circumstances*, the work of Nature could be vastly aided and improved by timely and appropriate interference.

This fine discrimination prevails throughout the whole field of medical practice. The cure of the common cold is still nature's inviolate secret, but we can work a vast improvement upon our natural immunity against diphtheria; while present-day therapy in pneumonia is a brillant advance over nature's equipment for the purpose. Nature maintains a degree of coordination between the different viscera which is a marvel of precision, but it sometimes elects to transform a normally functioning organ into a malignant tumor which, if left to itself, will kill the host. Here, surgical interference, by flouting nature's presumable intention, often saves the patient.

These deliberate intrusions are now taken for granted, and encounter no serious opposition, except in obstetrical practice. Here, in an important surgical specialty, any interference with natural phenomena has always been regarded as ostentatious and unholy; and the application of rational surgical principles and practices in this field has often met with disapproval, much of it, unfortunately, from within the ranks of the profession.

Let us return, for a moment, to two of the practices previously quoted-first, the "prophylactic forceps." It was a hardy and daring soul who originally proposed, (and within the recollection of most of us) that what might eventually prove to be a spontaneous delivery, be deliberately transformed into an operative procedure. Yet the reasoning here is preeminently sound. The advantages to both mother and child are clear and compelling, and an extensive test of this practice has fully justified it. Injuries to the child have been reduced in number and severity; trauma to the mother has been minimized through improved technical methods, for example, the episiotomy; and the risk of puerperal infection from such invasion of the birth canal has been found to be negligible. Experience has shown that, under present technical routines in properly conducted hospitals, puerperal infection of any degree is a rarity. The "prophylactic forceps" contributes very tangibly to better results, and is an outstanding example of the boon of rational surgery, wisely administered, to the practice of obstetrics.

---

*Presented Nov. 20, 1939 at the Monthly Clinical Conference of the Department of Obstetrics and Gynecology Yale University School of Medicine.

Secondly, in the field of abdominal, or Caesarean, delivery, those of us who were introduced to the problem in the early 20's, felt strongly the prudence and conservatism of the preceding generation, which was essentially one of experimentation and of only occasional resort to this procedure. Results in general were equivocal, to say the least, largely because a new and clumsy technique was coupled with a tendency to reserve the operation for the most desperate situations.

However, in the late 30's, our own private pavilion can report a series of 404 consecutive Caesarean sections, the indications for a great many of which would have been, in our student days, pure heresy, and which would probably not be specifically mentioned in any contemporary textbook of obstetrics. In this series there was one maternal death, a mortality of less than ¼ of one per cent. These results are of considerable interest, and are a source of deep satisfaction. However, on this occasion, I wish to emphasize but one angle, namely, the altered viewpoint. The actors in this drama are not obliged to defend their course, nor to apologize for their demeanor. The figures speak for them. And, in each of these 404 separate cases, under our own roof, and in our own time, someone has demonstrated that by a judicious and carefully considered program of action; by a combination of instinct, training, experience, analysis, and technical skill, he could outwit Nature; that he could do a better job than the natural resources of the patient could possibly do unaided. All of this, to be sure, has proceeded hand-in-hand with allied and associated advances-better anesthesia, wiser pre-operative and post-operative care, reduced operating time, a "stepped-up" efficiency of routine, and particularly, through the cooperation and ever-increasing skill of the pediatrician.

A thoughtful consideration of these matters is constantly punctuated with one underlying query, viz., "What are we doing to maintain a high level of professional competency as medicine continues its evolution?" The answer is all too obvious-a broader medical education for all, and a more intensive specialized — training for the few. Our objective in this respect should be, I believe, to give to every student a complete and serious exposure to the whole field of obstetrics, at least in theory, and with as much observation and practice as circumstances permit. This should accomplish several things: (1) the student can soon decide whether he wants to drop it, or to go on and master it; (2) if he drops it, he will still have an insight and appreciation which will enable him to recognize an obstetrical problem, no matter in what other direction he elects to specialize, and he will thus contribute to better obstetrics by getting such cases into expert hands as soon as they come to his attention; and (3) teachers of the subject will be at liberty to devote themselves more fully to the training of those who elect to qualify themselves as specialists. This method of training, rational in principle, simple of accomplishment, and promising in its results, is not uniformly in operation today, but there is considerable sentiment in its favor, and it is hoped that the pendulum will come to rest somewhere near this point.

In the discussion so far, the question of prematurity as an obstetrical problem has not been emphasized. At this point, however, the infant may properly be introduced, and in the further development of our main thesis, it will occupy an important place.

In the recent search for more effective methods of procedure, one which has aroused much interest and which has achieved considerable prominence is *the induction of labor.* This also is a deliberate perversion of Nature's plan, but the discriminating use of this device has been most satisfying and fruitful. Whereas many of these cases are done at or near term, on purely obstetrical indications, many others are done prior to maturity, and thus we intentionally impose upon ourselves, and upon our colleagues in pediatrics, the problem of the premature infant.

Induction of premature labor is most frequently practiced in the toxemias of pregnancy. Here we often find Nature attempting to do the same thing, in the same way, but in a fortuitous manner. The tendency toward spontaneous premature labor in chronic nephritis is second only to that in syphilis, but often the spontaneous termination of the pregnancy is ill-timed, and usually later than is desirable. In nephritis of pregnancy, most authorities advise termination upon establishment of the diagnosis. Many of these cases will fall in the so-called "premature" months between the abortion-and the term-phases of development, and many of those infants will be poorly endowed for survival. Often, in spite of a satisfactory birth-weight, and often in spite of a theoretically adequate term *in utero*, they will show *a congenital defective vitality*, a condition which may be very refractory to treatment. On the other hand, when a case of nephritis is carried to full term by whatever means we may, not only will the child still prove to be strikingly immature, as a rule, but also the mother's health will be seriously compromised by the continued metabolic strain. Nephritis of pregnancy and the problem of prematurity will, therefore, continue to go hand-in-hand, and probably more so, rather than less, as we proceed.

In frank eclampsia, labor is rarely in progress until the convulsive stage of the disease, a contingency which should be avoided in every possible instance, for, at that time, the life of the mother, as well as that of the child, is severely endangered.

Pre-eclampsia has come to be viewed in somewhat similar terms. Since the tendency to eclampsia, once established, rarely clears or even remains stationary, but rather, increases in severity, no matter what conservative measures are employed, a successful issue often depends upon one recourse, viz., removal of the offending cause, or, interruption of the pregnancy. Fortunately in these cases, the necessity for induction arises relatively late in pregnancy, and the babies do not uniformly show such immaturity as generally prevails in the nephritic group.

As a consequence, induction of labor in pre-eclampsia is now practiced much more extensively and with less hesitation than in former times, and, by and large, with exceedingly satisfactory results. This policy is the outgrowth of two factors: (1) the development of methods of induction which are relatively safe and dependable, and (2) the remarkable aptitude which pediatricians have shown in the successful rearing of these premature babies.

Quite as good a case could be made out for the management of pregnancy complicating heart disease, tuberculosis, diabetes, some of the anemias, hyperthyroidism, chronic infections of the urinary tract, habitual fetal death *in utero* near term, certain cases of multiple pregnancy, polyhydramnios, ante-partum hemorrhages, and selected cases of pelvic contraction. Induction of premature labor may, and often does, prove to be the wisest, or perhaps, the only rational and effective treatment.

The inescapable by-product of these problems is a premature baby, which is, admittedly, a problem in itself. However, is it not preferable to deal with a premature baby and a live mother who in many instances, may have been saved from an untimely death or from serious impairment of health, rather than to risk and perhaps lose the lives of both mother and child? Is it not preferable to induce labor a month before term in a chronic nephritic with advancing signs, and recover a five pound baby, with immediate relief of the maternal strain, rather than permit this patient to suffer further and perhaps irreparable visceral damage in order to secure a five and a half pound baby?

There is only one notable exception to this rule of procedure, viz., in syphilis. Here Nature will almost certainly provide us with a premature baby, often stillborn, and almost always diseased, unless we take steps to prevent it. Timely and appropriate therapy will not only result in a healthy child at term, in most instances, but, it is also established that the mother is peculiarly susceptible to the benefits of anti-luetic treatment during pregnancy.

It is very generally accepted and uniformly taught that "all other things being equal, the chance of survival of a premature baby varies in direct proportion to the birthweight." However, all things rarely *are* equal; practically every case is modified by variables. Yet, a determined and consistent effort should be made to provide the pediatrician with a baby which is developed to the maximum degree that circumstances will permit. Whenever we *elect* to bring a premature baby into the picture, the case should be carefully evaluated from this standpoint. Any enthusiasm or eagerness for purely obstetrical results must be tempered always by a serious consideration of this basic factor. In other words, we have not been given *carte blanche* to exploit pediatric skill, for the moment this is done, every party to the contract will suffer.

If then, we may sometimes *induce* prematurity, so to speak, with propriety and with high purposes in mind, and the pediatrician will so bear with us, we in turn are obliged to exercise every possible effort to limit to a minimum the *normal* incidence of premature births.

An exhaustive discussion of the measures available would involve every aspect of obstetrical practice, hence only a brief summary is possible.

In the earliest months, comparatively large numbers of abortions are inevitable. If circumstances permit prophylactic treatment, the routine measures should be supplemented by the administration of Vitamin-E and progestin, until such a time as these products have been more fully evaluated. Severe cases of hyperemesis should have early and vigorous therapy.

A comprehensive program of prenatal care includes timely, appropriate, and complete attention to acute and chronic infections, intercurrent illnesses, visceral pathology (organic and functional), and the toxemias.

In the daily routine the individual resources of each patient should be adjusted to the specific demands of the case; no single blanket recommendation will suffice for every patient. However, in every instance, the necessity of avoiding fatigue, exposure, strain, and trauma should be particularly emphasized.

The occasional pelvic neoplasm which threatens to disturb the complete development of the fetus, or its delivery at term, must be taken into account and removed if necessary, and if practicable.

Any and every deliberate interference with pregnancy prior to term must be on strict indication, and then deferred as long as is compatible with the mother's safety.

When the induction of premature labor is necessary, the case should, if possible, be hospitalized, chiefly for those benefits which accrue to the baby. For initiating pains the Vorhees bag or artificial rupture of the membranes, or both, may be recommended. Castor oil and quinine are less likely to be effective in the earlier months than at full term, but they may be used as an adjunct to the local measures. Pituitary extracts in the induction routine are better omitted, if possible, in these cases.

Analgesia in premature labor has been particularly condemned by some students of respiratory physiology, but sufficient degrees of sedation for a reasonably comfortable first stage do not appear to affect the baby with any consistent severity. Weight of opinion favors the barbiturates over the narcotics.

During the second stage of labor, anesthesia requires little or no modification from the customary routine. The tendency to a short and easy second stage automatically keeps down the volume of anesthetic gases employed.

If the delivery promises to be speedily accomplished spontaneously, no precautions need to be added, unless one elects to divide the perineum to just the degree which will eliminate all pressure on the head.

If the second stage is delayed, and the fetal head is arrested in transit, termination of the delivery by forceps is indicated. The obstetrical forceps do not squeeze the fetal head, but rather protect it against such trauma. In a large series of premature deliveries, Tyson found the lowest mortality in the group delivered by forceps, followed in turn by the Caesarean, the spontaneous, and the breech group respectively. In another large group, Ingram listed the order of safety as follows: forceps, spontaneous, version and extraction, and primary breech. The comparative safety of forceps delivery, and the large risk in breech cases are generally attested by experience, and it is not superfluous to urge again, the performance of external cephalic version in pregnancy, whenever it is possible.

The delivery room should be warm and free from draughts, and a high degree of humidity is desirable. Beside the heated crib, an assembled apparatus for the administration of oxygen and carbon dioxide should be in readiness to function without delay.

After delivery, measures for resuscitation must be carried out in a careful and discriminating fashion. Someone who is experienced and expert in this practice should be available at the time, if possible, so that the obstetrician can devote himself wholly to the mother.

The art of resuscitation is too big and controversial a topic for detailed discussion here, but, in the treatment of a premature infant, a few points can properly be emphasized.

1. The risk of injury, especially intracranial, is relatively high in prematurity. At birth, one can never be certain of the presence, or the possible extent, of this complication. Every gesture, therefore, must be carried out with the utmost caution to avoid any possible aggravation of such a lesion.

2. The oxygen and carbon dioxide mixture has proven a most satisfactory and valuable inhalant. There has been a recently renewed interest in the use of pure oxygen for this purpose, but it has not been widely accepted in view of the theoretical soundness of the Co_2 mixture and the excellent results attending its use.

3. A hot tub, especially in the unresponsive infant, is a particularly useful adjunct, and it often seems to be the most effective single factor in the routine.

4. Artificial respiration, in the classical manner, is useless and injurious. After cleansing the pharynx, preferably by gentle suction, the stimulating gases may be introduced by the mask or by tracheal catheter, but always under very low pressure. Mouth-to-mouth insufflation, under similar precautions, is a satisfactory substitute.

5. The best single index of progress is the heart beat, — its rate, regularity, and force. As long as this consistently improves under observation, treatment is succeeding, despite a possible lag in the respiratory response.

From this point onward, the problem is arbitrarily delegated to the pediatrician, but the essential continuity of the process must be recognized. Obstetrics and pediatrics must function in perfect harmony, according to predetermined and mutually approved plans which shall be devised by our combined experience and judgment.

In every obstetrical case, we gently touch the field of pediatrics, and promptly the life-lines begin to diverge, with hardly any realization of their momentary contact. In prematurity, however, those lines, the obstetrical and the pediatric, definitely cross each other, and remain crossed for variable lengths of time. When they finally meet again, and begin to diverge-slowly, hesitatingly-that new life goes on with a definite pediatric as well as obstetric inheritance. This area of common interest and mutual concern must be explored continuously by all of us in a spirit of congenial and sympathetic understanding.

⁂

NEW HAVEN HOSPITAL AND NEW HAVEN DISPENSARY—

Next Step in Development

A very attractive brochure has just been received bearing the above title. Aided by three full page cuts showing contemplated building improvements it presents the needs of this particular institution as they exist today. Hospital admissions during the past ten years have increased approximately 50% and Dispensary visits approximately 110%. The Hospital and the Dispensary must have additional endowment to meet the growing needs. An addition to the Private Pavilion to provide additional facilities for private and semi-private patients is contemplated at an estimated cost of $1,500,000. It is planned to modernize the present Isolation Pavilion at a cost of about $685,000. A third building requirement is found in the need for a Women's Pavilion at an estimated cost of $735,000. This appeal for financial aid has been extended, not only to citizens of New Haven but to all living within the State of Connecticut, such is the wide area served by the Hospital and the Dispensary.

The PROFESSIONAL EQUIPMENT Co.
X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS.
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

Digitalis U. S. P. XI

Recent Changes in Potency and Designation*

ARTHUR J. GEIGER, M.D.,
New Haven, Conn.**

Widespread obscurity, confusion, and controversy concerning the potency and designation of U.S.P. digitalis has prevailed since the last (eleventh) revision of the United States Pharmacopeia. Impressions and statements regarding digitalis potency range all the way from warnings, on the one hand, that the drug now distributed is twice as strong as that which prevailed under the U.S.P.X, to reassurances, on the other hand, that there has been no change of clinical significance.

From a review of practically all the controversial literature, from personal correspondence with several of the leading figures in the dispute, and through a questionnaire answered by twelve pharmaceutical firms, I think a reasonably reliable appraisal of digitalis potency may be ventured. Instead of offering a simple unqualified opinion, which would have no claim to authority, an attempt will be made to develop the subject step by step and indicate what appears to be the true course through this sea of confusion.

The tenth revision of the United States Pharmacopeia, which was in use until June 1936, required that all *official* preparations of digitalis be standardized on frogs by the one hour progressive dose method and compared with crystalline ouabain, whose unchanging potency was precisely known; the final strength of the digitalis under study was then so adjusted that the desired end-point (systolic arrest of the heart in one hour) was achieved by 600 mg. of the digitalis leaf per kilogram of frog. However, it has never been compulsory in this country for drug manufacturers to follow any specified method for digitalis assay, and many firms have preferred other frog methods and different techniques, among which the cat method of Hatcher and Brody[1] and its modifications have been popular. In brief, the cat methods determine the amount of digitalis which it is necessary to inject intravenously in a cat to cause death of the animal in a given time, and a "Cat Unit" represents the potency of an amount of the drug which is lethal per kilogram of cat.

Recent experiments by Edmunds, Moyer and Shaw[2] have again convincingly demonstrated a fact which is not new but has often been ignored; namely, that the various methods of digitalis assay and their modifications all give *significantly different end-points*, and that results obtained with one method cannot usually be translated into the terms of another. These differences with various methods have long caused much confusion and difficulty in the interpretation of investigative and clinical work throughout the world. In the interest, therefore, of promoting international uniformity in this matter, the Health Commission of the League of Nations more than a decade ago urged the general adoption of a universal standard of digitalis potency. To this end a blended digitalis powder obtained from several sources was adopted in Geneva in 1925 as the proposed *international standard powder*, 0.1 Gm. (1½grains) of which was designated as the "International Digitalis Unit". Sealed ampules containing samples of this powder were then prepared in London and made available to all nations for use as a standard with which any country might compare a *digitalis reference powder* of its own preparation and determine its potency in terms of the *international standard powder*.

The eleventh revision of the United States Pharmacopeia in 1936 adopted three sweeping reforms in the matter of digitalis standardization. The use of ouabain as the U.S.P. standard for digitalis assay was dropped, and in its place the international standard digitalis powder was given official recognition; an "U.S.P. Digitalis Unit" was created to correspond in potency with the "International Digitalis Unit"; and the U.S.P. authorized the preparation of an *U.S.P. digitalis powder* of such strength that 0.1 Gm. would contain one "U. S. P. Digitalis Unit" (or one "International Digitalis Unit"). In other words, U.S.P. digitalis was to be made identical in potency with the international standard digitalis powder. This necessitated, of course, that first a *reference powder* of digitalis be prepared and its potency determined in relation to the *international standard powder*. This was done. A mixture of digitalis leaves obtained from the United States and Europe was prepared as the *U.S.P. reference* or *standard digitalis powder*. Its assay and comparison with the *international standard powder* revealed a potency considerably greater than that of the international standard; for example, Edmunds, chairman of the Committee on Bio-Assays of the U.S.P., and his associates[2] found that 0.745 Gm. of the *U.S.P. reference powder* corresponded in potency with 1.0 Gm. of the *international powder*. This *reference powder*, therefore, when "diluted" by approximately 33 per cent, or when employed in assays with the correction factor of 0.745, would correspond with the potency of the *international standard powder*.

---

*Presented before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

**From the Department of Internal Medicine, Yale University School of Medicine.

In summary, then, the U.S.P. Digitalis Unit and the International Digitalis Unit were made identical, and each represented the potency of 0.1 Gm. of their respective official powders.

It next became of clinical importance to determine the potency of new U.S.P. *XI reference* or *standard powder*, (employed with its proper correction factor), in relation to the former U.S.P. X standard, which was ouabain. This question was soon answered by Edmunds and his associates [2], [3] and others [4], [5], all of whom agreed that the new U.S.P. XI digitalis was 25 to 30 per cent stronger than the old U.S.P. X drug, which meant that in clinical practice physicians who prescribed digitalis in terms of weight of the powdered leaf, or volume of the tincture, would have to modify their dosage accordingly.

No confusion need have arisen at all if these simple facts had been adequately brought to the attention of the medical profession. Unfortunately, that was not done. The U.S.P. XI described the new method of assay and New and Non-official Remedies of 1937 referred to it in a single sentence. These references, however, are probably consulted by but few practitioners and are not the proper media for general education. For almost three years the subject was not mentioned at all in medical literature, and the only reports and discussions of the changes in digitalis potency appeared in pharmaceutical journals. It was not until December, 1938, that a casual footnote in a paper by Fahr[6], on the treatment of cardiac irregularities, suddenly awakened the conciousness of physicians to the fact that since 1936 they had probably been using a digitalis of significantly increased potency.

Inquiries into the esoteric literature promptly corroborated Fahr's general contention but revealed a disturbing controversy among workers in the field concerning the magnitude and clinical significance of the change in digitalis potency, and questions directed to pharmacologists and pharmaceutical firms confirmed that a state of extraordinary confusion existed.

Analysis of the literature up to July, 1939 led to the following conclusions:

1. That U.S.P. XI digitalis was approximately 25 to 30 per cent more potent than U.S.P. X digitalis on the basis of weight of the drug. This opinion was based largely on the convincing report of the extensive experiments by Edmunds, Moyer and Shaw[2], and the confirmatory observations of Smith[4]. Since then Edmunds[5] has indicated that Chen's studies stand in further agreement; and finally, six pharmaceutical firms, among twelve questioned, have expressed their opinion that U.S.P. XI digitalis is from 25 to 30 per cent more potent than was U.S.P. X digitalis (see chart I).

2. That several workers who reported considerably greater increases in the potency of U.S.P. XI digitalis had probably employed the U.S.P. *reference digitalis powder* without application of the proper factors to correct for its excessive potency in relation to the *international standard powder*. At any rate, when Edmunds[3] applied such factors to the two most important dissenting reports[7], [8] the results

were brought, perhaps fortuitously, into close harmony with those of Edmunds, Moyer and Shaw[2].

3. That several other discordant reports were based on experiments [7], [9] showing such wide difference in individual assays that faulty technique must be inferred.

4. That confusion has been introduced by arguments based on introconversion of results obtained by various frog and cat methods of assay, which are generally known to bear no necessary quantitative relationship to each other.

The weight of acceptable evidence, therefore, is in favor of regarding U.S.P. XI digitalis as 25 to 30 per cent more potent per given weight than the U.S.P. X product used prior to 1937, and the implication is that physicians must modify their former dosage principles by approximately one-fourth. Additional study of this controversial question may require further modification of the opinion here expressed.

It would seem appropriate to this discussion to state some views on the use of terms for prescribing digitalis. In the decade ending in 1936, during which the U.S.P. X was official, it became customary with some physicians to think of digitalis dosage in terms of Cat Units instead of weight of the officially standardized powdered leaf or volume of the tincture. Justification for this practice was attributed to the fortuitous circumstance that 0.1 Gm. (or 1½ grains) of the officially frog standardized drug happened to be approximately equivalent in potency to one Cat Unit as determined by the Hatcher and Brody method of assay[1]. Some pharmaceutical firms even conveniently labeled their product in terms of Cat Units. However, the Cat Unit is not an absolute value unless the assay conditions are adhered to with precise uniformity. The speed of injection, the use of artificial respiration, changes in anesthetic and barometric pressure, and many other factors are known to influence the end-point of the cat method of assay. Cushny, quoted by Smith[4], stated that in the case of a given sample of digitalis submitted for assay to different laboratories by the League of Nations, it had required twice as much of the same digitalis to kill cats in Edinburgh as it had in London. Many pharmaceutical firms employed modifications of the original Hatcher and Brody procedure which resulted in a Cat Unit that was not the equivalent of 0.1 Gm of official U.S.P. X digitalis, and the practicing physician was probably not usually aware of the resulting differences in potency that prevailed between one brand of digitalis and another. The concept of the Cat Unit, therefore, always seemed to me arbitrary and impractical, and I formerly favored the administration of digitalis in terms of weight or volume of the officially standardized drug obtained preferably from a single reliable source.

While it appears theoretically valid that differences in Cat Units by different techniques and different workers tend to disappear when the assays are performed against an *international standard digitalis powder*, nevertheless the Cat Unit still seems an inconvenient and undesirable designation now that it no longer enjoys the former accidental virtue of being equivalent in potency to 0.1 Gm. of U.S.P. digitalis. Since the recent adoption, by the U.S.P. XI, of a clearly defined and universally uniform Digitalis Unit, a Unit which represents the potency of 0.1 Gm. of digitalis by either U.S.P. or international standard, the retention of the inconstant Cat Unit concept would seem entirely outmoded in clinical practice and undesirable in investigative work that desires international appraisal.

Although more than three years have elapsed since the advent of the U.S.P. XI, several pharmaceutical firms have not yet brought their digitalis into conformity with the U.S.P. recommendations. As a result, the products marketed at present differ in potency and in the designation of their biological strength, which makes for confusion in therapy unless the physician knows the current status of the particular brand that his patient receives. A safe general rule is to prescribe digitalis in terms of U.S.P. Unit strength; the pharmacist will then dispense any one of several officially standardized brands whose biological effect will be uniform.

The following tabular description of various brands of digitalis is based on answers received to a questionnaire that was submitted to all the pharmaceutical firms whose digitalis is accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

CHART I

Drug Firm	*Name of Product*	*Assay Method*	*Reference Basis*	*Potency Designation*	*Potency Change since* 1936
Abbott	Digitalis & Digipoten	Official U.S.P. Frog	U.S.P. Standard Powder	U.S.P. Units	Uncertain
Ciba	Digifoline	H-B cat* modified	U.S.P. Standard Powder	Cat Units	No change
Davies, Rose & Co.	Digitalis	Official U. S. P. Frog	U.S.P. Standard Powder	Weight—Vol.	Increased
Hoffman-LaRoche	Digalen	H-B Cat modified	Not U.S.P. Standard	Cat Units	No change
Lederle	Digitalis	H-B Cat modified	U.S.P. Standard Powder	Cat Units	No change
Merck	Digitan	Official U.S.P. Frog	U.S.P. Standard Powder	Weight—Vol.	Increased 30 - 50%
McNeil	Digitalis	Official U.S.P. Frog	U.S.P. Standard Powder		Increased† 10%
Sharp & Dohme	Digitalis	Official U.S.P. Frog	U.S.P. Standard Powder	U.S.P. and Cat Units	Increased 25%
Squibb	Digitalis	Official U.S.P. Frog, and H-B Cat.††	U.S.P. Standard Powder	U.S.P. and Cat units	Increased 25%
Upsher Smith	Digitalis	Official U.S.P. Frog	U.S.P. Standard Powder	U.S.P. Units	No change**
Wilbur	Digitalis	H-B Cat	Not U.S.P. Standard	Cat Units	No change
Wyeth	Digitalis	Official U.S.P. Frog	U.S.P. Standard Powder	U.S.P. Units	Increased

*H-B refers to Hatcher-Brody cat assay method.

†Under USP X the McNeil assays were carried to highest permitted limit, now to lower limit; hence, net increase in potency is small.

**International (now also USP) Unit in use since 1931; hence no change since 1936, but product allegedly 25 to 30 per cent more potent than USP X digitalis.

††Two lines of digitalis products dispensed; one variety assayed by official USP Frog method and labelled in USP units; the other assayed by Hatcher-Brody method and labelled in Cat units.

The author's attendance at the United States Pharmacopeial Convention of May 1940 afforded a unique opportunity to verify further the above views by conversation with numerous other delegates. The concensus among the pharmacologists and clinicians questioned was in agreement with the opinions already expressed; namely, that U. S. P. XI digitalis has a potency about 30 per cent greater than U. S. P. X digitalis.

REFERENCES

1. Hatcher, R.A., and Brody, J.G.: The Biological Standardization of Drugs, Am. J. Pharm., 82: 360, 1910.

2. Edmunds, C.W., Moyer, C. A., and Shaw, J. R.: The United States Pharmacopeial Standard Digitalis Powder, J. Am. Pharm. A., 26: 290, 1937.

3. Edmunds, C W.: The Potency of Digitalis Preparations of the 1936 Pharmacopeia, J.A.M.A., 113: 284, 1939.

4. Smith, F. A. U.: The International Unit of Digitalis, J. Am. Pharm. A., 20: 471, 1931.

5. Edmunds, C. W.: Personal Communication.

6. Fahr, G.: The Treatment of Cardiac Irregularities, J.A.M.A., 111: 2268, 1938.

7. Rowe, L.W., and Pfeifle, H.W.: The U.S.P. XI Standard for Tincture Digitalis, J. Am. Pharm. A., 27: 182, 1938.

8. Wright, H.N.: The Potency of Digitalis Standardized According to U.S.P. XI, J.A.M.A., 112: 1180, 1939.

9. Munch, J.C.: Report for the Committee on Physiological Testing, J. Am. Pharm. A., 26: 1096, 1937.

Treatment of Gonococcal Salpingitis and Arthritis With Sulphanilamide*

ROBERT M. LEWIS, M.D.,
New Haven, Conn.

In discussing the results obtained in cases of gonoccal salpingitis treated with sulphanilamide we must be careful to define our objectives—to distinguish clinical symptomatic relief from cure which presupposes a complete eradication of the gonococcal infection.

If one remembers this distinction it will be easier to understand the contradictory statements which fill our literature on the subject.

A recent medical article speaks of "curing" 44 of 45 cases of gonococcal infection in women from 2 to 9 weeks, Here, the criterion of cure was the taking of 3 negative smears at successive weekly intervals — an entirely inadequate evidence of cure.

We are all agreed that successive smears and cultures taken over a period of many months, particularly postmenstrually, are necessary to establish a cure.

Carpenter, A. Cohn, and others have shown that cultures will very often prove the presence of gonococci when many successive smears are entirely negative. This has been our own experience.

Sulphanilamide gives early symptomatic relief in nearly all kinds of gonorrheal infection. It also early distorts the gonococcus in such a way as to render its detection difficult or impossible on smears. So let us not talk of "cures" unless many months have elapsed after treatment has been instituted.

Long remarks that while sulphanilamide therapy falls short of the ideal method of treating acute gonorrheal salpingitis, it probably approaches it more nearly then any other method at one's disposal. With this we entirely agree.

In reporting 120 cases of acute and subacute gonococcal salpingitis treated with sulphanilamide he finds that acute cases do better than the subacute. Acute symptoms of pain, tenderness, and fever usually subside in from 2 to 4 days.

Long-standing chronic cases owe their symptomatology to adhesions, misplacements, etc., and should not be treated with sulphanilamide.

I have been interested in observing the results of treatment at the Kingston Ave. Hospital in Brooklyn, where female court cases of New York City infected with gonococci are segregated and only released after 4 negative smears and cultures taken at weekly intervals have been secured. This is a matter of legal requirement and is not taken as an index of cure.

Here in a series of about 100 cases of gonococcal salpingitis Long's findings were confirmed, but it was also noted that after pain and tenderness were gone, many weeks were often required for the pelvic masses to subside.

In less than 50% of these cases was sulphanilamide apparently a success in producing only 4 successive negative cultures and smears.*

The method of administration of sulphanilamide with its dangers and the precautions to be used are too well known to need lengthy description.

Briefly, I believe that best results are obtained by: —

1. Having patients put to bed, preferably hospitalized.
2. Administration of small doses is almost or quite worthless. If the disease is serious enough to treat — do it thoroughly.
3. In the adult treatment should begin with 80 grains daily for 3 days — 60 grains daily for 3 more days — then 40 grains daily up to 2 weeks. If not cured or greatly improved stop in 14 days, or sooner.
4. No patient with R.B.C. or Hgb. less than 50% should be treated.

Blood counts should be taken at least every

---

*Read before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

48 hours during the 1st week of treatment. Treatment should be *stopped* if sudden anemia, fever, rash, severe nausea, vertigo, etc., occurs.

5. Soda Bicarbonate one dram daily in divided doses should be given.

6. Water must be limited to 1000 c.c. daily to avoid too rapid elimination and severe concentration of the drug.

Gonococcal Arthritis

Only recently, fever therapy was considered the last word in the treatment of gonorrheal arthritis. In fact it was said that if a case did not rapidly yield to this form of treatment, one might assume that it was not of gonococcal origin.

Few of us have seen a great number of these cases — the few that I have seen have been in children and did well with sulphanilamide.

Keefer reports that results with sulphanilamide surpass those obtained by any other method. Of his 14 cases, 12 were cured in from 14 to 48 hospital days. He found that cases with pain, periarticular swelling and little effusion responded best, while infected joints with sterile blood cultures were the most refractory to treatment.

Others find that involvement of one or more small joints respond much better to sulphanilamide than do cases in which the larger joints are involved. Again dosage must be substantial. Newer sulphanilamide derivatives may, in the course of time, give even better results than sulphanilamide itself. I have seen cases cured by sulfapyradine which sulphanilamide had failed to cure.

At present I believe that sulphanilamide is of enormous value in treating gonorrheal salpingitis and arthritis.

☆☆

THE FIVE DAY TREATMENT FOR SYPHILIS

The widespread newspaper publicity regarding the so-called "five day treatment of syphilis" makes it desirable to issue for the non-medical public a statement of the facts, the origin of the method, the reasons for its importance, and its present limitations, according to Walter Clarke, M.D., in the Journal of Social Hygiene for May, 1940. A brief resume of the present status of the treatment may be welcome to our own readers. The five day treatment utilizes the intravenous method of administering an arsenical in early syphilis in males. At first neoarsphenamine was used, later replaced with a new drug called phenylarsine oxide. In the 86 patients treated with neoarsphenamine the results were satisfactory in 91 percent. Too short a time has elapsed to judge the results in patients treated with arsine oxide.

It is believed from the present experience that the intravenous method of treatment is not without danger and should only be administered in hospitals under expert supervision. It cannot be recommended for general adoption, as by private practitioners, until a large volume of experience has been accumulated under careful hospital supervision and the necessity for the supplementary therapeutic agents has been determined. Experience with this method of treatment is limited to a single class of cases, namely, early syphilis in males. Nothing is as yet known of its applicability to latent or late syphilis, or to syphilis in women, whether pregnant or not, or to cases of congenital syphilis in infants and children.

☆☆

TOTAL DISABILITY

In a recent issue of the New York State Journal of Medicine an editorial calls the attention of the readers to the importance of physicians giving mature consideration to just what constitutes total disability when called upon to testify in cases where disease or accident has taken its toll. If one will refer to the decision of the St. Louis Court of Appeals in Missouri referred to in the Journal of the American Medical Association, January 13, 1940, it will be clear that to be totally disabled it is not necessary to become inert and absolutely helpless. If it can be shown "that his infirmity renders him unable to perform, in the usual and customary manner, substantially all the material duties of his own occupation, business or profession or of any other occupation, business or profession which his age, training, experience, education and physical condition would fit him for except for his disabling infirmity," he is totally disabled. Bearing this decision in mind, it should be easier for the physician of Connecticut to render a decision or offer testimony as to the degree of total disability present.

Pneumo-Myelography in the Diagnosis of Spinal Cord Lesions*

BERNARD S. BRODY, M.D.,†
New Haven, Conn.

In the past few years, owing to the renewed interest in the etiology of low back pain, there has been a great increase in the number of patients subjected to spinal studies with contrast media. As a result of this tendency, we find a revival of the question as to whether lipiodol is entirely a safe contrast agent.

There does not seem to be any question but that the injection of lipiodol into the subarachnoid space is followed by a mild meningeal reaction lasting a few days. This, however, is also true of air, or oxygen and other foreign substances. Because of this temporary irritative effect lipiodol should not be used in inflammatory conditions. Experimental work has shown that lipiodol injected intrathecally in animals will produce a low grade arachnoiditis with the formation of cysts containing fat. On the other hand, Globus reported 138 cases in which lipiodol had been used. The condition of 65 patients was checked after several years; in one instance as late as 10 years following the injection. Only one patient complained of increased back pain. Roentgenograms were made of 34 of these patients. The lipiodol was still seen to move freely and there was no appreciable reduction in the amount of oil present. Three of these patients subsequently came to autopsy. No evidence of leptomeningitis was found. Globus concluded from this report that lipiodol was a safe diagnostic aid in man.

The literature contains many reports of the late effects of lipiodol injected intrathecally. The interpretation of these reports must take into consideration the fact that some of these patients were suffering from a progressive nervous system disease and, in others, a laminectomy had been done which in itself might have caused local adhesions with cyst formation. In the large number of laminectomies for removal of ruptured discs that have been done at the Mayo Clinic, no visible evidence of irritation of the meninges or nerve roots was noted at operation. It has been customary at this same clinic to use 5 cc. of oil for an injection and it was demonstrated that in time the oil tends to be transported out along the sheaths of the caudal nerves where its presence, so far as it was observed, seemed to give rise to no symptoms or signs.

Dandy in 1918 first suggested the use of air to outline the spinal canal. It should be said that myelography with air is often not as clearly localizing as is lipiodol. Spinal air injections are also discouraging at times because of technical difficulties in adequate filling of the subarachnoid space. This of course is reminiscent of the difficulty occasionally encountered in attempting to fill the ventricles with air. In patients with a complete subarachnoid block there is no need for using lipiodol. A few cc. of air is injected into the lumbar canal, with the patient in the sitting position. The bubble of air will rise to the lower level of the obstruction and can be seen easily in the x-ray.

With the increasing number of cases being investigated in the light of the newer pathogenesis of low back pain, many patients will have lipiodol injections and very likely many will show no intraspinal pathology. It is in these cases particularly that an air injection should be done first. Should this procedure reveal no suspicion of a filling defect, lipiodol can be avoided. If, however, the air x-rays are indeterminate or inadequate, oil should be injected. For visualization of the lumbo-caudal sac, the patient is placed in the Trendelenberg position at an angle of 30 to 45 degrees. The needle is inserted into the second lumbar space. Spinal fluid and air are exchanged in 5 cc. volumes until 30 to 35 cc. of air are injected. Lateral projections are obtained before the patient is turned for the antero-posterior view. Following this procedure the patient is kept in the Trendelenberg position for 8 hours, flat for 24 hours and is gradually elevated to the erect position in 48 hours. In this way, very little headache is experienced by the patient.

303 Whitney Avenue.
789 Howard Avenue.

---

*Presented before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.
†From the Department of Surgery, Yale University, the School of Medicine, New Haven, Connecticut

Association of Connecticut Tumor Clinics

Sixteenth Meeting of the Association,

Meriden Hospital, Meriden, March 7, 1940

E. W. FOSTER, M.D., Chairman

During the last two years at the Meriden Hospital Tumor Clinic a concentrated drive has been carried on to make the staff tumor conscious so that suspected cases will be referred to the hospital early. Without quoting figures it seems that cases are coming in much earlier than before, and that our efforts have not been in vain.

One of the poorest records as far as early entrance to the hospital is concerned is in the ovarian tumor group. It is obvious at the outset that the end results in cancer of the ovary will be bad because of the insidious onset and lack of early symptoms in many of these cases. It was with the hope of bettering our results in these cases that this group was examined.

1. Gynecological Cases. — A. Review of carcinoma of the ovary — E. W. Foster, M.D.

(Slides and Pictures shown)

From March 1935 to March 1940 there were 160 surgical specimens of malignant neoplasms sent to the Meriden Hospital Laboratory. Of these 53 were carcinomas of the female genitalia and of these fifty three, 20 were malignant tumors of the ovary. These figures mean that the hospital has a large number of gynecological cases in proportion to general surgical cases but nevertheless the number of ovarian malignancies is quite high.

This report covers 19 cases seen in the last four years which were diagnosed as ovarian malignancy by the pathologist. The non-malignant tumors such as teratomas, pseudomucinous cystadenomas, serous cystadenomas, fibromas, etc., were excluded. The fact that these patients have not gone five years renders the mortality statistics of no value. However, many pertinent facts are shown by the study and several conclusions seem to be warranted.

Of these 19 cases, one was a pseudomucinous cystadenoma with a sarcoma, 6 were serous cystadenocarcinomas, 8 were solid carcinomas. Of these solid tumors, one was a Krukenberg tumor, one a granulosa cell tumor and two were psammocarcinomas. The duration of the symptoms was from three days to thirteen years. It is not fair to say that these symptoms were due to cancer from the beginning. The two longest cases were those who had symptoms ten and thirteen years. These cases undoubtedly had symptoms from non-malignant cysts which later became malignant. One of these patients had a large abdominal tumor ten years ago and I tried to send her to the hospital at that time. Two years ago she was operated and a very large cyst was removed which showed carcinoma. She is alive still. The patient with the thirteen year history had one ovary removed in 1926. Symptoms soon recurred. A biopsy was taken in 1937 and a slow-growing psammocarcinoma was found. She is still alive with cancer and ascites. The shortest history was of only three days duration; symptoms were severe pain due to a ruptured cyst. The average duration of symptoms before operation was 20 months, which startling fact makes me feel that our statistics in these cases may be immensely improved.

Symptoms were pain, distention, constipation, increase in size of the abdomen, mass in the abdomen, irregular menses, increasing menses, cough, weakness, fatiguability. The one patient with granulosa cell tumor was 65 years of age and had not bled since her menopause. Only three patients had uterine bleeding prolonged or irregular.

The treatment of these cases was by surgery. Complete hysterectomy was done in only three cases. Bilateral oophorectomy was done in three cases; unilateral oophorectomy was done in four cases. Laparotomy and biopsy were done in nine cases. In some cases one ovary was removed because the size of the cyst and the adhesions present made it good judgment to do no more at the time. In one case in which one ovary was removed it was stated that the other was normal. There were no operative deaths in the series of 19 cases.

Six patients are now alive, one with symptoms and the others feeling well. There is a mortality of 69%.

Of the cases who had a biopsy only, one is now alive. This is the patient with a psammocarcinoma who has lived two years since her biopsy. These patients lived an average of 44 days exclusive of the one who is alive. It does not seem that removal of an ovarian tumor when metasteses are already general prolongs life and it may even shorten it. Sometimes it seems worth while to give the patient a temporary relief from abdominal pressure by removing a tumor but it certainly does not prolong life.

Of the three patients who had both ovaries removed only one is alive, sixteen months after operation.

Of the three patients who had complete operation, two are alive, having lived four years and sixteen months, respectively.

Of the four patients who had one ovary removed, two are alive, one three and a half years and one two years.

It would appear undesirable to spill the cyst contents at operation but as nearly as it can be shown in this short series it makes little difference whether this is done or not. Three of the living patients had cysts content spilled.

If it is at all possible to do a complete operation it is most desirable. The two patients who had complete operations would seem to prove that radical surgery is satisfactory.

The patients still alive were reported briefly. The two following cases were of special interest:

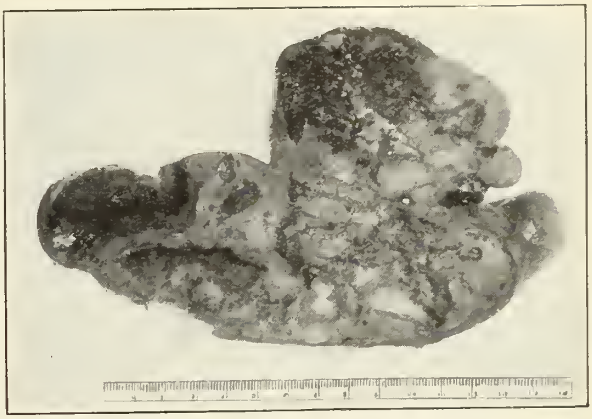


Figure 1.

Granulosa cell tumor of ovary, with hydrothorax.

This tumor involved the left ovary of a white woman of 65 years, who was admitted because of non-productive cough, loss of weight and shortness of breath. She was found to have a pleural effusion on the right side and a mass in the region of the left ovary. This pleural fluid was drawn off and cultured, found to be sterile and examined for tumor cells of which none were seen. The left ovary was removed. Two years have elapsed since this operation. The patient has been in excellent health and there is no evidence of return of the hydrothorax. It is interesting to note that this patient never had vaginal bleeding since her menopause.

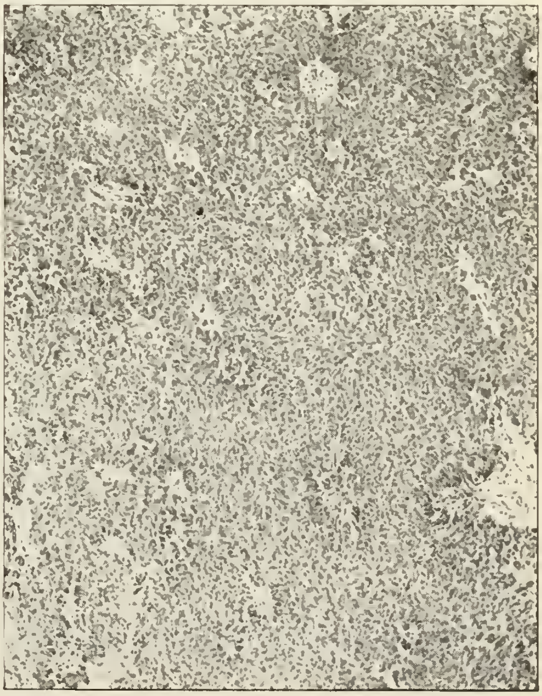


Figure 2.

x 90

Tumor of granulosa cell type.

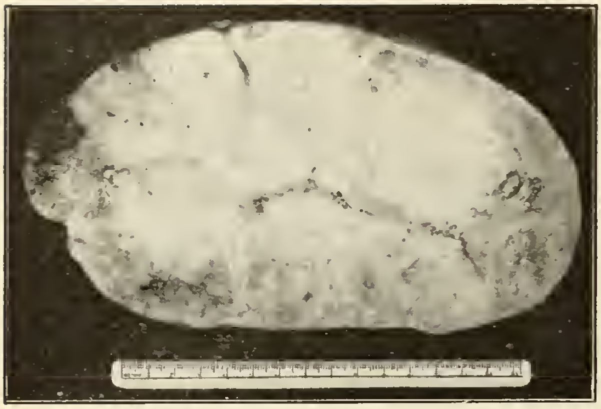


Figure 3.

Krukenberg tumor of ovary.

This patient had a scirrhous carcinoma of the stomach which was removed on 10/14/35 when she was 40 years old. She remained apparently well for 2 years following the operation but then began to have attacks of backache. Two weeks before readmission on 6/14/39 she noticed that her abdomen was increasing in size. At operation both ovaries were found to be the seat of large ovoid masses measuring 20 x 12 x 10 cm. and 15 x 8 x 7 cm., respectively. The cut surface exuded a large quantity of mucoid material and the tissue contained occasional hemorrhages. The patient died apparently of intra-abdominal and cerebral metastases in August of 1939.

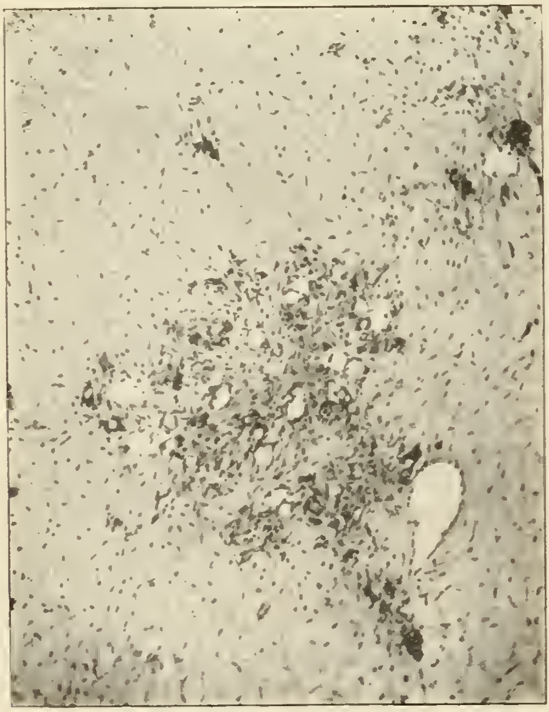


Figure 4

Krukenberg tumor of ovary. — x 90

Note the signet ring cells, small acini, and edematous stroma.

So little x-ray was used in these cases that I believe it hardly worth while to comment on it. Meigs' opinion that x-ray prolongs life but does not cure is undoubtedly true and we should use more x-ray than we have been using.

Summary

Nineteen patients with malignant tumors of the ovary are reviewed. The average age of these patients was 60 minus, the average duration of symptoms was twenty months.

1. It seems justifiable to conclude that these patients could have been brought to surgery earlier in many cases.

2. Radical surgery is the best treatment. Both tubes and ovaries and the uterus should be removed.

3. Pelvic masses should be removed as soon as diagnosed without waiting for the signs of malignancy, i.e., pains, constipation, increase in size of the abdomen, fluid.

4. Operation is justified in advanced cases since occasionally a cure can be affected.

DISCUSSION OVARIAN CARCINOMA

Doctor Frederick C. LaBrecque, Waterbury

Recently I made a study at St. Mary's Hospital in Waterbury on one phase of ovarian malignant tumors, the papillary cystadenocarcinomas. I chose all the tumors diagnosed as such from 1935 to the present time. Of a total of nine patients, three are alive. One was operated on in 1935 for a cyst with twisted pedicle which was confirmed at operation. Papillary cystadenocarcinoma was found microsopically. The ovary was removed, the patient received x-ray therapy and she is alive and well to-day with no evidence of recurrence. The second patient who is alive was operated on a year ago, at which time extensive metastases were found and she is now dying. The third one was admitted recently for saphenous vein ligation and she was found, on routine examination, to have an ovarian cyst. She was operared and is to receive x-ray therapy.

Several interesting points were revealed by this survey. Seven of the nine operated on (six of whom are dead) had extensive metastases at operation. With one exception the duration of symptoms was only two and a half months, and symptoms were, in the order of frequency, lower abdominal pain, loss of weight and appetite, and fatigue. Only four patients complained of slight change in menses, and five had no change. In view of the fact that the duration of symptoms was only two and a half months, this paper demonstrates that cancer of the ovary is a difficult cancer to detect. The duration of life following diagnosis was only seven months. The patients who have a good prognosis are the patients in whom the cancer was found accidentally.

Apparently, the only way we are going to diagnose these patients early is by an annual physical examination. Both those cysts which were precursors of the cancer would have been picked up on physical examination before they became cancer. Two and a half months is a short duration of symptoms when extensive metastases were found in so many cases, but with a more general use of the annual physical examination we may be able to diagnose them earlier, find and remove cysts and adenomas, etc., which may be potential cancers, and thereby improve the results in carcinoma of the ovary.

Doctor Norman C. Margolius, Waterbury

In the records of the Waterbury Hospital there are 48 cases of primary cancer of the ovary during the period from June 1931 to January 1940.

Grossly, these tumors were of many types — cystic, solid, solid and cystic, large, small, papillary, smooth-walled, hemorrhage, etc. Histologically, they included papillary cystadenocarcinoma, medullary adeno-carcinoma, teratoma, folliculoma malignum (granulosa cell), embryonal carcinoma, fibrosarcoma, pseudomucinous papillary cystadenocarcinoma.

In order to evaluate the five year end results the cases were divided into two groups, (1) from June 1931 to December 1935, (2) from January 1936 to December 1939.

Group 1 — 22 cases, of which six are living and well after five years with a survival rate of 27.2%. Sixteen patients died within five years, making a mortality rate of 72.8%.

Analysis of time of death after treatment:

9 died within 6 months	56.25%
11 died within 1 year	68.75%
14 died within 18 months	87.5 %
15 died within 3 years	93.75%
16 died within 4 years	100

Group 2—26 cases, of which eight are living. Eighteen patients died, making a mortality rate of 69.23% already, as compared to a five year rate of 72.8% in Group 1. This group includes many cases which were recently operated on, but in spite of this the mortality rate already closely parallels that of Group 1.

Analysis of time of death after treatment:

12 died within 6 months	66.66%
15 died within 1 year	83.33%
17 died within 18 months	94.4%
18 died within 3 years	100%

In analyzing the deaths, in the great majority of cases the disease was far advanced and many were inoperable. In most cases, cancer had broken through its capsule and involved surrounding structures and many were bilateral.

In the favorable cases, operation was performed early when the cancer was stil encapsulated.

The two cases of tertoma are worthy of mention. In one the treatment consisted of simple removal. The patient died of a recurrence 18 months later. In the other a panhysterectomy was performed in 1936. She shows no evidence of the disease at present.

The record of the Waterbury Hospital for cancer of the ovary is far from satisfactory, but is undoubtedly comparable to the result obtained by most other hospitals throughout the country. Apparently, if a case of cancer of the ovary lives for three years after operation the chances are a permanent cure has been obtained. The cases that have been cured are all of the early type that have been operated on before the cancerous masses have penetrated the ovarian capsule. The problem is to diagnose these cases at the time of the annual physical examination and to advise operation when a suspicious feeling ovarian mass is palpated. Of course, if this procedure is followed routinely, many benign follicular cystic ovaries will be removed and the patients subjected to an unnecessary operation, but nevertheless it is only by removing these cystic tumors that we can ever hope to reduce the incidence of cancer of the ovaries that now occurs.

Doctor Charles L. Larkin, Waterbury

I have had two cases of granulosa cell tumor. One patient was operated upon for a large ovarian cyst of the left ovary and it was deemed wise to remove the uterus and the small right ovary which appeared to be normal, but on examining the routine microscopic slide of tissue taken from the small ovary it was found that there was a small granulosa cell tumor present. This tumor apparently had not been doing the patient any harm and was found only by chance. The other case of granulosa cell tumor was in a woman over fifty years of age who came into my office with a history of having started to show vaginal bleeding again after a period of amenorrhea. A cancer of the fundus of the uterus was suspected and a dilatation and curettage was performed but very little endometrium was obtained. Nevertheless, it was deemed advisable to insert 100 mgms. of radium for 24 hours. The laboratory report at this time showed a cystic hyperplastic of the endometrium. This is a very important finding in a woman who has had her menopause, for it always indicates ovarian activity caused by some pathological condition of the ovary, and although no cyst of the ovary could be palpated at that time and as I did not recognize the importance of the finding, I trusted to the radium to take care of the local condition. Two years later, the patient was examined in the course of her annual physical examination and an ovarian mass could be felt. The patient was advised to have a laparotomy but refused. Later she went to Dr. Studdiford of New York and he succeeded in persuading her to have an operation; the cyst was removed and found to be a granulosa cell tumor.

Doctor Stanley B. Weld, Hartford.

I can see that Dr. Larkin is not the only one who has a liking for his theme song. I also believe that the annual physical examination is probably the only thing we have to fall back on in order to improve the prognosis in carcinoma of the ovary. It is certainly true that if you see your women patients every year you will find these ovarian cysts and potential as well as real cancers. Doctor J. V. Meigs of Boston shows in his figures that he had a better percentage of results in cases that were operated on and had no deep x-ray therapy in both solid and papillary carcinomas, than in those that had deep x-ray treatment as well. Those patients who had x-ray irradiation may have enjoyed a few months longer life, but the discomfort in many instances was so great that it was hardly worth it. It is also a fact that many of these patients are so obese that x-ray irradiation is worthless. The thing that counts most, of course, is to remove all the tumor tissue surgically, if possible.

Doctor Douglas J. Roberts, Hartford.

It is considered pretty generally that the results of radiation in the treatment of ovarian cancer are fairly limited. Dr. Fred Stewart from the Memorial Hospital in New York sometime ago attempted to chart the radiosensitivity of different types of ovarian tumors. He found on one side the embryonal types of tumors which were quite radiosensitive. The curve dropped to the relatively non radiosensitive, reaching its peak in the simple and rather adult form of adenocarcinoma. As this type of tumor becomes progressively more cystic and then more papillomatus it becomes more radiosensitive and the papillary cyst-adenocarcinoma with psammoma bodies shows approximately the same radiosensitivity as the purest embryonal type of tumor. This would seem to have some value in the prognosis when this form of therapy is to be considered.

Doctor L. L. Walton, Hartford.

At Hartford Hospital several years ago we reviewed 95 ovarian neoplasms. They were 66 papillary cystadenocarcinomas, 14 solid adenocarcinomas and 17 embryonal tumors. We found on charting the frequency of symptoms that pain and a mass were the most common complaints. The following conclusions were arrived at as a result of the study. Two-thirds of ovarian cancers are cystic. Prognosis is much better in cystic tumors. Five year arrests: Cystic 26%, solid O, and embryonal 13%. Presenting and outstanding symptoms are abdominal pain and swelling. Over half the cases are hopeless when first seen. Operative mortality is 12.5%. Spilling of contents is not necessarily of bad prognostic omen, although it is not recommended. Bloody ascites is evidence of fatal disease. Radiation prolongs life.

1. Gynecological Cases. B. Sarcoma of the Uterus — Averill A. Liebow, M.D.

Sarcoma of the uterus is not so rare as to be a curiosity. In 2½ years three examples were encountered at the Meriden Hospital which will be presented together with a brief review of some of the main features of the subject.

Sarcomas may arise from the myometrium, or from the endometrial stroma. More rarely they may be mixed mesodermal tumors containing heterologous elements or, sometimes, "carcinosarcoma". Possibly many of the latter are really not sarcomas at all but represent a dedifferentiated form of carcinoma. Perhaps about 2% of all malignant tumors of the body of the uterus are sarcomas, but the incidence is variously stated because of difference of opinion relative to the diagnosis of malignancy in the somewhat anaplastic, but clinically benign, well circumscribed fibromyomas or sarcomas of the uterus that often confront the pathologist.

Case 1.

Leiomyosarcoma

The patient was a widow of 28 years who had had one child now 8 years old. She was admitted on 6/5/39 stating that 3 months before admission she had become aware of a lump in the lower abdomen. There was no deviation from the regularity or character of the menses. Upon physical examination a smooth mass was palpated three quarters of the way to the umbilicus. There were no signs of pregnancy. At operation the uterus was found to be symmetrically enlarged and was thought to contain a myoma but when a longitudinal incision was made by the pathologist the uterine cavity was found to be distended by a large fluctuant cystic mass which contained a cloudy amber fluid together with a small quantity of gelatinous material. The wall of this mass was seen to be composed of fleshy, resiliently firm, pink tissue which made up one quarter or less of the thickness of the wall of the uterus and reflected anteriorly to form the wall of the cyst as shown in Figure 5. Upon its fundic aspect this sarcoma tissue came into relation with a much firmer flattened fibromyoma from which it was distinguished along a sharp edge. The uterus measured 14cm. from the level of amputation to the serosal aspect of the fundus.

Histologically the tumor consists of small oat-shaped cells, some of which, as shown in figures 6 and 7, are in mitosis.

This patient is still alive after a simple hysterectomy performed nine months ago.

Comment.

This tumor fulfills the cytological criteria of malignancy but was not invasive and clinically showed no evidence of metastasis. The patient's youth is not unusual. The presence of cystic change is occasionally observed in these tumors.

Case 2.

Sarcoma Arising From the Endometrial Stroma

A white woman of 54 years was admitted to the Meriden Hospital on 1/17/39 complaining of vaginal bleeding and of backache. Her last regular menstrual period had occurred 10 months before but since this time she had two episodes of severe uterine hemorrhage lasting

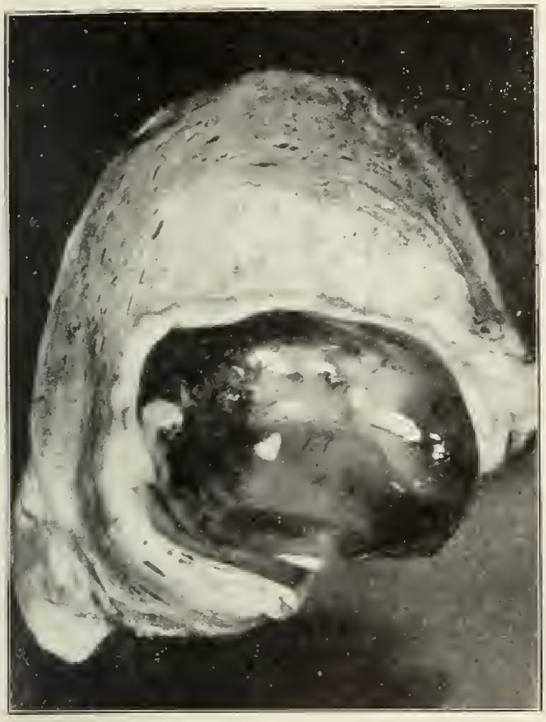


Figure 5 — Case 1.
Leiomyosarcoma with cystic change delimited from fibromyoma (above, toward fundus).

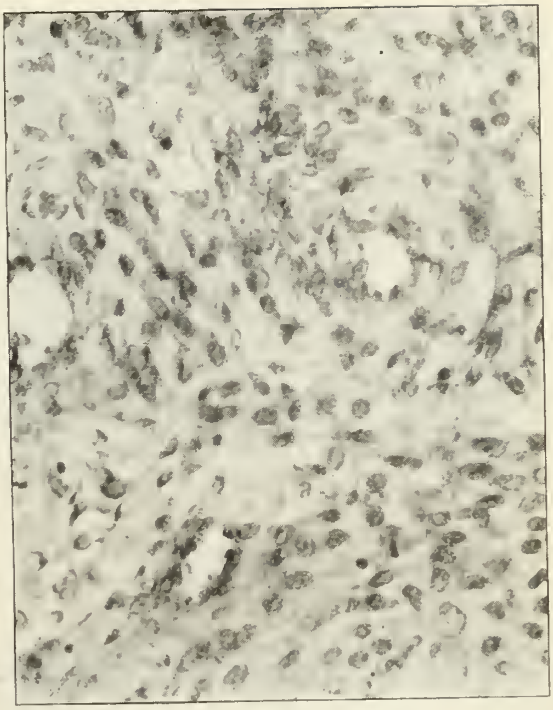


Figure 7. — Case 1. x 375
High power showing cytology and occasional mitoses.

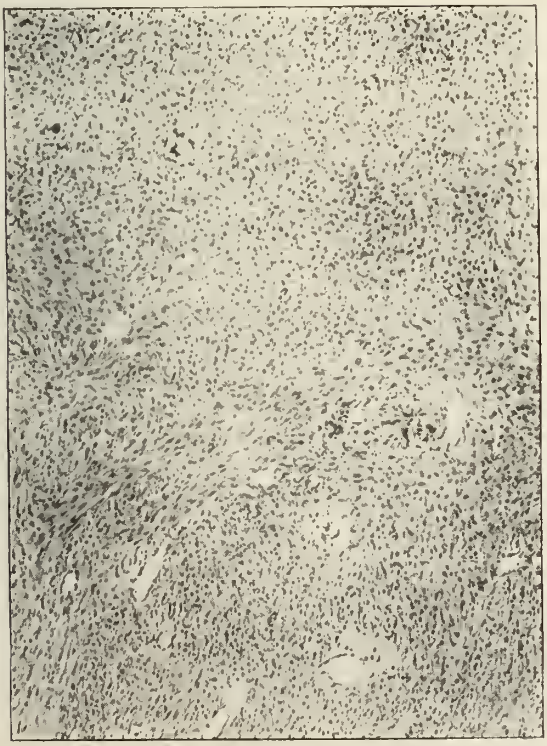


Figure 6. — Case 1. x 90
Low power showing oat-shaped cells in interlacing bundles.

several weeks. In the interval there was a thin watery discharge. Two days before admission she began to bleed even more severely than before. Physical examination discovered an irregular nodular mass in the pelvis several times the size of a normal uterus. This was thought clinically to be a myoma. At the time of laparotomy several cherry red nodules, each about 5 cm. in diameter, were found sessile upon the omentum and fat of the posterior abdominal wall. (Figure 9). A frozen section of one of these showed the presence of sarcoma tissue. The uterus was now removed together with the tubes and ovaries. A median sagittal section of the organ which measured 10 cm. from the serosa to the level of transection, 6½ cm. antero-posteriorly and 6½cm. transversely, showed the presence of a finger-shaped polypoid mass projecting downward from the roof and posterior wall into the uterine cavity. The tissue of this mass (Figure 8), differed from the several small subserosal fibromyomas that were present in having a much more homogeneous appearance, greater translucency and softness and a pale pink color, except in its distal 2 cm. where it was rendered dark red by

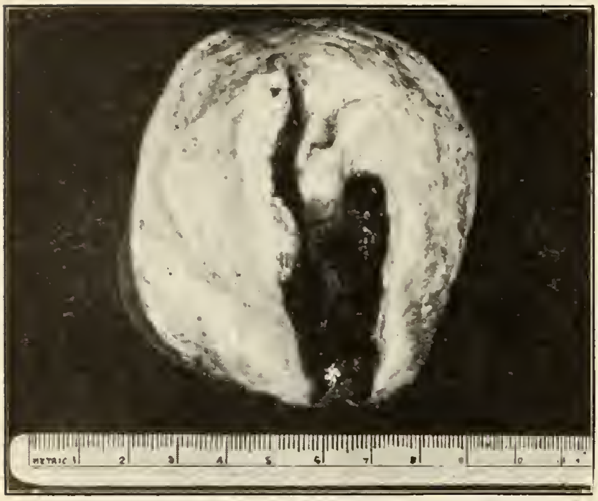


Figure 8 — Case 2.
Gross, showing polypoid mass projecting from posterior wall and fundus.

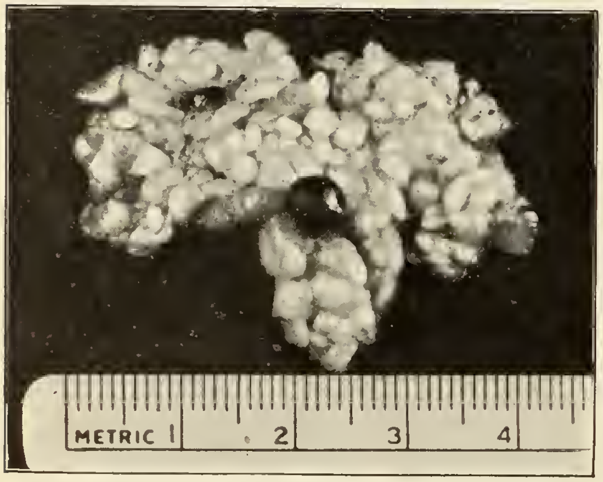


Figure 9 — Case 2.
Metastasis from omentum (slightly magnified)

extravasation of blood. The histology of this nodule (Figure 10) was that of a spindle cell sarcoma. The cells resembled those of the endometrial stroma in their small size and basophilia. Occasional mitoses were present.

The patient is still alive and apparently well, despite the fact that metastases were seen at operation more than one year ago.

Case 3.

Mixed Mesodermal Tumor of the Body of the Uterus

This white woman of 59 years complained of pain in the abdomen and of a scanty sanguinous vaginal discharge for 2½ months before her admission on 10/11/37. Her menopause had come at 47 after a normal menstrual life beginning at 13. Vaginal examination showed a bleeding and partially necrotic mass protruding through the external os. This was excised by cutting the pedicle with scissors. The surgeon stated that its attachment was high in the fundus. Histological examination showed the polyp to consist of a polymorphous, sarcomatous stroma containing irregular acini and islands of cartilage. (Figure 11). The uterus, cervix, and adnexae were then extripated on 11/15/37. The region thought to be the base of the polyp showed deeply invading irregular acini embedded in a myxomatous stroma which was devoid of cartilage or other heterologous elements. There were no evidences of metastasis at this operation. On December 19, 1938, however, the patient was readmitted complaining of abdomial distention and nausea of 5 weeks duration. The chest was clear to percussion and auscultation. At the exploratory laparotomy performed on 12/20/38, numerous exceedingly firm nodules were found in the floor of the pelvis and within the mesentery and omentum. Histologically

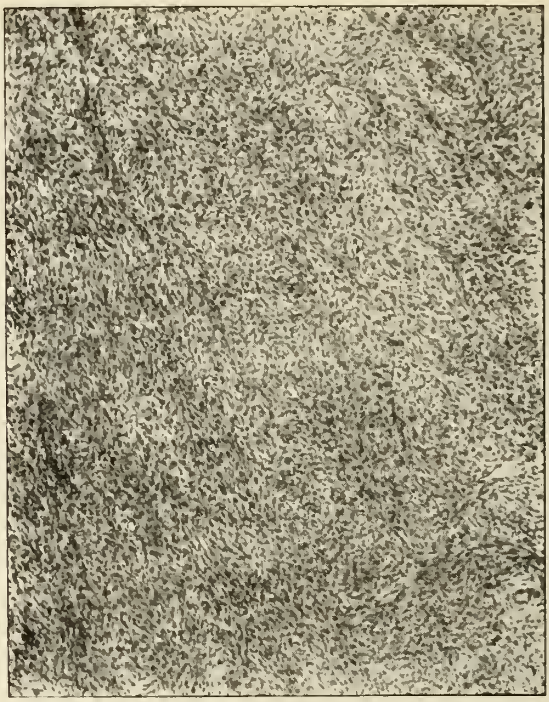


Figure 10 — Case 2.x 90
Histological section, low power, showing deeply staining spindle shaped cells.

these consisted of myxosarcoma and carcinoma but did not contain cartilage. The patient died at home on January 22, 1939. A necropsy was not performed.

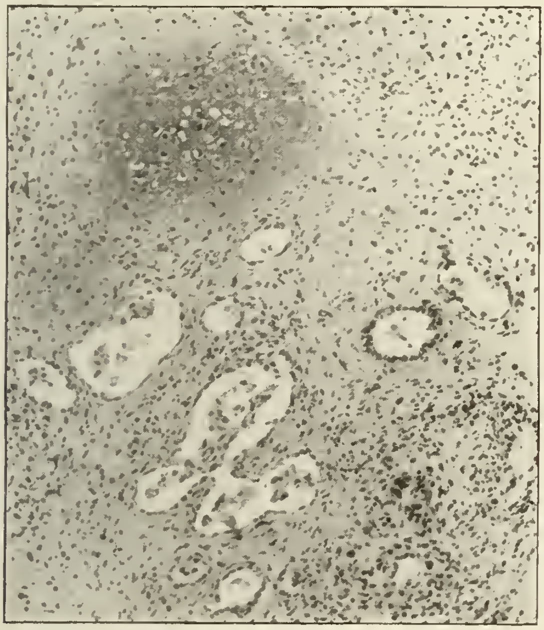


Figure 11 — Case 3.
Histological section showing polymorphous stroma containing a typical acini and islands of cartilage.

DISCUSSION SARCOMA UTERUS

Doctor J. O. Collins, Waterbury.

Where rare tumors are concerned, the experience of an individual clinic is largely a matter of chance. For instance, at St. Mary's Hospital in Waterbury we have seen in the last two Brenner tumors, a granulosa cell tumor, a dysgerminoma, and two Krukenburg tumors, all relatively rare tumors of the ovary. At the Waterbury Hospital, where the larger total number of ovarian tumors are seen each year, only one of the above group has come to light in the past seven years, this being a Krukenburg tumor associated with carcinoma of the stomach. As for uterine sarcomata, each institution has recorded only one case. At St. Mary's Hospital, a 52 year old patient with both myosarcoma of the myometrium and adenocarcinoma of the endometrium died three months after panhysterectomy. There were metasteses to the lungs suspected of being sarcomatas, but autopsy was not obtained, so definite proof as to the character of the metastases is lacking. At the Waterbury Hospital, a patient with a cervical polyp having histological features of sarcoma has remained well for three years following removal of the polyp, fulguration of its base and application of 2400 mgm. hours of radium.

Doctor Walton, Hartford.

Novak reported 59 cases over a 25 year period at Johns Hopkins Hospital. There was a five year salvage of 30%.

Doctor Ralph E. Kendall, Hartford.

At Hartford Hospital there have been about 16 sarcomas in fifteen years. The mortality is very high as there are only two still alive and they have gone three years. All the rest have died promptly. The youngest was nineteen years old.

Doctor Louis P. Hastings, Hartford.

In the past ten years we have seen six sarcomas of the uterus, none of the mesoblastic type. Two were of the stroma (?) type and the others of the smooth muscle type. One of the stroma (?) type is still living after three years. I do not know what the percentage is

2. Care of Inoperable Cancer — A. The Medical Viewpoint — T. P. Murdock, M.D.

There is hardly anything new from the medical viewpoint in the management of inoperable cancer. I think, however, this management should be placed under three general headings: (1) Common Sense, (2) Good Judgment, (3) Balance. After many years experience I think I can say that if the general practitioner or surgeon or internist does not possess these qualifications or if he does not develop them quickly, he probably never will and he will not be successful in the management of inoperable cancer nor able to adequately treat the patients coming under his care.

During the course of an inoperable cancer, a very common syndrome which develops is lack of appetite, nausea and vomiting. As is customary with any inoperable situation or any symptom associated with an inoperable situation, the pharmacopoeia is reviewed in an endeavor to correct those symptoms. The latest is the Vitamin B complex. We have tried thiamin chloride and nicotinic acid for lack of appetite, nausea and vomiting without success. However, I think there is one weapon in the management of the nausea and vomiting which I have observed over a period of several years, if it is associated with primary or metastatic involvement of the liver or acidosis. It is intravenous glucose and if it can be given unostentatiously or without fanfare it will allow the patient hours and perhaps a day of relief.

As he goes along the way he will probably develop serous effusions. Then comes the judgment of the general practitioner or surgeon or internist as to whether or not this should be permitted to stay there or be relieved. This judgment is not easy, but if the patient is going to live only a matter of a few weeks and it is a pleural effusion, let him keep it and have that much comfort. I know that almost all surgeons would say "that is only a needle prick," but a man who died within the past year and whom you all know and who contributed much to medicine telephoned a friend to come and see him the morning he was taken ill. He told the attending physician he thought he had indigestion but the attending physician thought he had coronary disease and sent him into the hospital. The man objected to going because he "did not want them to stick a lot of needles in me." He was dead in twenty-four hours. We must think of this situation from the standpoint of the patient.

Of course, the chief complaint of these patients is pain, and what are we going to do about it? Let us come back to good judgment, balance and common sense. You should try to evaluate how long the patient is going to live and if you study your patients, you can become accurate in your judgment. If he is going to live eighteen months or so and is complaining of pain, start him with aspirin and not morphine. Get it up to ten or fifteen grains every three or four hours, and add codeine later on. Still later on add morphine by mouth and then finally by hypodermic. It is possible to get these people up to half a grain every two hours and keep them comfortable. A new preparation which is not well known and which is satisfactory when morphine has outlived its usefulness is Schlesinger's solution, made up of morphine, dionin and scopolamine. It can be given by mouth and later on by hypodermic.

In the last five years cobra venom has been much talked of. We have had limited experience with it and with that limitation it has not been effective. Its physiological action is thought to be central and the drug is not habit forming, and the tolerance is not increased. The effect is obtained after the drug has been given for several days. It is cumulative in its action and in this respect resembles digitalis. One cubic centimeter a day is given for several days and then a maintenance of one cubic centimeter a day or every other day. If one is to get a satisfactory response it will be noticed on the fifth, sixth or seventh day. If no results is obtained by that time, probably none will be. The venom is marketed in 1 c.c. ampules containing five mouse units each. A mouse unit is the amount of venom required to kill a 22 gm. white mouse in eighteen hours. As I said, we have not had the success with it that we have had with the narcotics, particularly with morphine and occasionally with Schlesinger's solution.

I come now to my final and favorite part. These people should not be told that they have cancer. Most men do not agree with me. Death itself is not hard for these people but the anticipation of death is horrible. For a criminal about to be executed the anticipation is always worse than the death itself. I feel very dogmatic about this. Occasionally a patient will tell you to let him know if he has cancer. If you tell him he has hypertension he probably will faint, so how can you tell him he has inoperable cancer. Very few people can accept the knowledge that they have cancer. Often their plea is that they wish to get their houses or businesses in order but if they met sudden death they would not have time to settle their affairs anyway. That is one criticism of cobra venom. It gives the patient a sense of well being and his mental processes are pretty clear. Narcotics do not let him think clearly and in this way aid him a great deal.

2. Care of Inoperable Cancer.

B. What the Neurological Surgeon can offer — Max Taffel, M.D.

The neurological surgeon may be called upon to play a dual role in far-advanced malignant disease. The first and foremost concerns the relief of intractable pain, and the second the treatment of expending lesions which have metastasized to the central nervous system.

Relief of Intractable Pain

It is imperative constantly to bear in mind that there are at present available a relatively large variety of methods which may be safely and effectively used to alleviate pain. If the patient cannot be offered a cure of his malignant lesion, he can in most instances be relieved of pain and allowed to spend his last days in relative comfort. Pain is mediated through two divisions of the nervous system, the somatic and the automatic. The relief of pain is effected, therefore, by the temporary or permanent paralysis of the sensory pathways of either or both of these systems. This paralysis may be produced by surgical division of the involved nerves or by injecting them with an injurious chemical agent such as alcohol. The procedures available for interrupting sensory pathways may be outlined as follows:

- I. Trigeminal Nerve
  - A. Alcohol injection of the peripheral divisions.
  - B. Intracranial differential section of the root.
  - C. Avulsion of the peripheral branches of the 1st division.
- II. Glossopharyngeal Nerve
  - A. Intracranial section.
- III. Antero-lateral chordotomy
- IV. Posterior rhizotomy
- V. Anterior median myelotomy
- VI. Peripheral nerve division or resection
- VII. Automatic nerve division or resection.
- VIII. Alcohol injection
  - A. Trigeminal nerve.
  - B. Peripheral nerves.
  - C. Autonomic nerves.
  - D. Caudal nerves.
  - E. Intrathecal.

I. Alcohol injection of the branches of the trigeminal nerve may be employed to relieve pain in far advanced cancer of the face, mouth and tongue in which the anticipated span of life is short. The 2nd and 3rd divisions of the nerve are readily accessible and may be injected at the sites where they pass through the foramen rotundum or ovale, respectively. The procedure may be performed under a local anesthetic, without subjecting the patient to any undue discomfort. A successful injection is followed by complete anesthesia of the areas innervated by the nerve. The duration of the anesthesia varies, on the average, from six to twelve months, at the end of which the pain may recur with the regeneration of the nerve. The injection may then be repeated. However, because of the presence of scar tissue which develops after the first contact with the alcohol, the second and third injections may not reach all the nerve fibers and the subsequent relief of pain may be incomplete and of short duration. For tumors in the forehead, the supraorbital and supratrochlear nerves may be avulsed through a small incision in the inner aspect of the eyebrow and the pain controlled for several months.

Differential intracranial section of the sensory root of the trigeminal nerve is indicated: 1. in tumors which have enroached upon or invaded the base of the skull in such a manner as to render the main peripheral branches of this nerve inaccessible; 2. where a relatively long survival period is expected; 3. where there is in addition neoplastic invasion of the pharynx which requires division of the 9th nerve. The operarive approach to the trigeminal nerve is usually through the subtemporal extradural route. Where simultaneous section of the 9th nerve is also planned both nerves may be reached and divided through a suboccipital craniotomy. The resulting anesthesia and freedom from pain are permanent. Because of the often expressed fear by the laity and indeed by many members of the profession as well, it should be emphasized that the procedure when competently performed does not result in a motor paralysis of the face and is tolerated well, even by elderly patients.

II. The control of pain in tumors of the pharynx by paralysing the 9th cranial nerve has already been refererd to. This nerve, not accessible to alcohol injection, is divided intracranially. The resulting anesthesia is permanent.

III. Antero-lateral chordotomy refers to the surgical division of the lateral spino-thalamic tract which carries the pain pathways of both the somatic and autonomic systems. A selective and permanent anesthesia to somatic and visceral pain is obtained below the site of the section, the upper limit of this anesthesia being determined by the level of the section as well as the depth to which the spino-thalamic tract is divided. This procedure may be utilized for painful and extensive primary or metastatic tumors of the trunk and lower extremities. Painful lesions of the shoulders and upper limbs may also be attacked by a cervical chordotomy. However, because of the proximity of the phrenic nerve roots, the operation here is attended with an appreciable risk of respiratory paralysis. The procedure can for the most part be performed under novocaine anesthesia. Nitrous oxide may be temporarily administered during the manipulation of the cord and section of the tract, after which the patient is allowed to regain consciousness and the level of the anesthesia carefully determined. The chordotomy may be unilateral or bilateral, depending upon the site of the pain and the probable future direction of growth of the neoplasm. Of the postoperative complications specifically related to this procedure, urinary retention is the most frequent and often the most distressing. As a rule this disturbance is only temporary, lasting from several days to several weeks, but it may persist even longer, especially in those instances where the tumor invades the pelvis and its viscera. Transient motor weakness and abdominal distention due to edema of the cord at the level of the section are also observed. In general, these complications occur more frequently and are more lasting after bilateral than after unilateral cord section.

IV. Posterior rhizotomy may be employed to relieve pain of limited distribution in the trunk, chest, shoulders and head. It is of particular value as a safe substitute for high cervical chordotomy. The exact roots concerned in alleviating the pain must be localized, bearing in mind the frequently extensive overlap from somatic sensory nerves and the uncertain levels at which the automatic sensory fibers enter the cord. To help assure relief of pain, the posterior roots of the segment above together with those of the segment below the painful area are included in the section. The anesthesia is permanent. Failure to relieve pain is in most instances attributed to inaccurate localization of the involved roots and to the division of an insufficient number of these roots. Since deep pressure, position and temperature sense are destroyed as well as the pain sense, the patient may be left with a relatively useless limb though the motor functions are perfectly intact. Posterior rhizotomy is therefore probably not the procedure of choice for tumors of the upper extremities. The operation may be followed by temporary urinary retention.

V. In anterior median myelotomy the section passes through the anterior commissure of the cord and includes the sensory fibers as they decussate in the grey matter in front of the central canal. The indications for this procedure are essentially the same as those for posterior rhizotomy. The area of pain must be carefully mapped out and the corresponding segment of the cord transected. As in anterolateral chordotomy the pain fibers of both the somatic and autonomic systems are included in the section while the position and deep pressure sensations remain intact. Unlike chordotomy, however, the anesthesia occurs in limited dermatomes and does not involve the entire body below the level of the section. During the operation care must be taken to spare the anterior spinal vessels from any injury which may lead to troublesome hemorrhage or to thrombosis with subsequent and permanent cord damage. This procedure, although sound in theory, has because of its technical difficulties not been widely used.

VI. Peripheral nerve division and avulsion may be used to relieve pain of tumors of the extremities and in superficial tumors of the trunk and chest. The involved nerves must be accurately localized and adequate allowance made for overlap. All forms of sensation are interrupted. The duration of the anesthesia varies directly as the distance between the nerve section and the site of the pain.

VII. Section of the autonomic nerves for relief of pain has thus far been confined almost entirely to the presacral nerve plexus which courses retroperitoneally over the promontory of the sacrum. This plexus carries the automatic fibers from the pelvic viscera, and its division may relieve purely visceral pain but will in no way effect the pain resulting from direct invasion or pressure of the tumor upon adjacent somatic sensory nerves. The results of presacral nerve section are at best uncertain. The procedure should probably not be undertaken as a primary objective in itself but may be carried out in the course of a pelvic exploration where an inoperable tumor is encountered. The plexus can usually be located easily and divided.

VIII. The injection of nerve fibers with absolute alcohol is a valuable means for controlling pain of both somatic and visceral origin. The degeneration and paralysis of the nerve result in anesthesia and freedom from pain which last up to twelve months. Reference has already been made to injection of branches of the 5th cranial nerve. Paravertebral injection of the intercostal nerves may be effectively used for painful tumors invading the thoracic cage. The striking and beneficial results which have been reported after alcohol injection of the dorsal autonomic nerves and ganglia in angina pectoris and in aortic aneurysms suggest the similar employment of this method for painful tumors of the thoracic and abdominal viscera. It has, however, not been widely used in the treatment of inoperable tumors, and its potentialities in this respect are now not known. The technical details are not difficult to master and its use should be considered in tumors of the thoracic or abdominal organs where the pain is mediated by way of the autonomic system and where more extensive procedures are for one reason or another contraindicated. Pain in neoplasms about the anus and perineum may be controlled by paravertebral alcohol injection of the caudal nerves.

Since its introduction in 1931 by Dogliotti, the intrathecal injection of alcohol for the relief of pain has been increasingly widely used, often without the proper indications and without the full knowledge and realization of the possible complications. The method is based upon the fact that alcohol has a lower specific gravity than spinal fluid upon which it will layer and float. As in posterior rhizotomy, the distribution of pain must be carefully determined beforehand and a sufficient number of segments injected. In order to avoid injury to the cord and the motor roots, absolute alcohol is used in amounts not exceeding 1 cc. per interspace. The injection is performed slowly and the position of the patient is not changed for at least two hours. Although theoretically available to control pain mediated by any of the posterior roots, this method has been most advantageously employed in tumors involving the pelvic viscera. The injection is easily performed and may be attempted in those instances where the general condition of the patient or the anticipated span of life do not warrant the performance of an extensive operative procedure. The results of the method are, however, uncertain. Relief of pain when it does occur may vary in duration from several weeks to several months. Troublesome motor weakness and urinary disturbances are not uncommon sequelae. Intrathecal alcohol injection has a very definite and useful place in the control of pain. The uncertainties of the method and its complications are emphasized because of its present widespread and often indiscriminate use.

The specific procedures available for effectively relieving pain produced by neoplasms in the various regions of the body are outlined in Chart I. Several methods are available for the same region. The nature and location of the neoplasm, the distribution and the character of the pain, and the general condition of the patient must be considered in determining the procedure of choice. Preliminary spinal anesthesia or injection of novocaine into the peripheral nerves may often aid in determining the effectiveness of the procedure under consideration and the site of its performance.

Treatment of Intracranial and Intraspinal Metastases.

The intracranial and intraspinal cavities are frequently the sites of metastatic neoplasms. Such metastases are often multiple, but occasionally single solitary deposits are encountered. Metastatic lesions in the spine, by compressing the cord and the adjacent roots, may produce pain, urinary and rectal disturbances, and may lead to a complete anesthesia and paralysis below the level of the lesion. Unless the patient is too feeble to stand the operative procedure or the life expectancy very short, a laminectomy should be performed to decompress the cord. This may at first sight appear to be a heroic but futile gesture. However, unless this is done the patient is condemned for the remainder of his short life to a bedridden, paralytic existence, aggravated by the many discomforts which accompany incompetence of the urinary and rectal sphincters. Laminectomy should be considered especially in those cases of slowly growing neoplasms which have metastasized to the spine and suddenly caused a complete functional transection of the cord. The earlier the decompression is performed, the more rapid and more complete the return of function. There are instances of carcinoma of the prostate with paralysis due to cord compression where, following laminectomy, the patients were able to return to a useful existence for periods as long as eighteen months.

Solitary metastases to the brain produce the same disturbances as primary expanding intracranial lesions. The general and the specific localizing neurological symptoms depend

CHART I.

Method for Relieving Pain	Forehead	Face Mouth Tongue	Pharynx	Neck Shoulder	Thoracic Viscera	Thoracic Wall	Upper Abdominal Viscera	Lower Abdominal Viscera	Anus and Perineum	Upper Extremeties	Lower Extremeties
Trigeminal Nerve											
A. Alcohol injection		+ +									
B. Intracranial section		+ +									
C. Avulsion of branches of first division	+ +										
Glossopharyngeal Nerve											
A. Intracranial section			+ +								
Antero-lateral Chordotomy				+(?)	+ +	+ +	+ +	+ +	+ +	+ +	+ +
Posterior Rhizotomy				+ +	+ +	+ +	+ +			+(?)	
Anterior Median Myelotomy				+(?)	+(?)	+(?)	+(?)			+(?)	
Peripheral Nerve Division and Resection						+ +					+ +
Autonomic Nerve Division or Resection								+ +			
Alcohol Injection											
A. Trigeminal Nerve		+ +									
B. Peripheral Nerves						+ +				+(?)	+(?)
C. Autonomic Nerves					+(?)		+(?)	+(?)			
D. Caudal Nerves									+ +		
E. Intrathecal					+(?)	+(?)	+(?)	+ +			+ +

+ + = Suitable method. +(?) = Method attended with risk or uncertain result.

upon the location of the tumor and the rate of its expansion. Intracranial symptoms are often the first and presenting ones, and no clue may be available as to the metastatic nature of the lesion until its exposure and removal at operation. Craniotomy for resection of the tumor or for decompression of the brain should be considered in single metastatic lesions of the brain which produce severe headaches, vomiting, blurring of vision, convulsions or paralyses in patients with slowly-growing tumors who are otherwise in good condition. The procedure is purely a palliative one and should not be looked upon with more disdain than a palliative gastroenterostomy for far advanced carcinoma of the stomach, or colostomy for an obstructive cancer of the large bowel. It is often a matter of delicate judgment to determine which patient should be subjected to craniotomy. The general condition of the patient, the expectancy of life, the rate of growth of the primary tumor, the presence and distribution of other metastases, and the solitary or multiple nature of the focus in the brain should be considered in making the decision.

State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

Efficiency of Serological Tests for Syphilis in Connecticut

FRIEND LEE MICKLE, SC.D., and
EARLE K. BORMAN, M.S.,
Hartford, Conn.*

The Bureau of Laboratories participated in the 1939 Evaluation Study conducted by the Committee on Evaluation of Serodiagnostic Tests for Syphilis appointed by the Surgeon General of the United States Public Health Service. This is the third annual evaluation study that was open generally to state department of health participation and the third in which this Department has taken part, as the original study conducted in 1936 was open only to a selected list of laboratories. The results obtained in the 1937 study[1] and in the 1938[2] evaluation have been published.

These inter-state evaluation studies have been conducted to determine on a nation-wide basis the relative abilities of the central laboratories in the 48 states to detect cases of syphilis by performance of serodiagnostic tests. The history, aims and accomplishments of this important activity designed to supplement and make possible the carefully planned program for the control of syphilis in the United States have been published[3] [4] [5] [6] in several medical and public health journals and so require little comment here.

The Bureau of Laboratories availed itself of the first opportunity offered to determine how good or how poor were our methods of performing the several tests for syphilis. We made a very creditable showing in the first study and we have been able to profit from participation in each annual study with the result that the sensitivity of the several tests performed in the Bureau has been greatly increased without lowering the degree of specificity. Today more sensitive tests for syphilis are being performed than ever before and yet these tests yield fewer false positive results. This fact has real significance to the physicians in Connecticut who use the services offered by the Bureau.

Under the evaluation study plan about 300 blood specimens are submitted annually to each participating state laboratory. Two-thirds of the specimens in each study come from individuals in the various stages of syphilis, some treated and some untreated, the donors being so selected that the serums of most of them would be expected to contain small amounts of reagin, the substance that reacts in laboratory tests to give positive findings. The remaining 100 or so of the donors are selected as presumably non-syphilitic individuals. Portions of all blood specimens are furnished to each participating laboratory by number so that the laboratory, when it examines and reports on the specimens, has no clinical data regarding the patients. A control laboratory, and usually the author of the particular test as well, examines portions of the same specimens. The United States Public Health Service, after tabulating and analyzing the data, gives to each laboratory a rating for sensitivity and a specificity rating. The Commissioner of Health in each state is furnished with a summary of the findings made by all participating laboratories but only the laboratory in his own state is identified to him by a key number.

---

*Director and Assistant Director, Bureau of Laboratories.

The 1939 Study

In the 1939 study the Bureau of Laboratories examined 334 blood specimens. Whenever possible the three tests performed day by day on the samples submitted by physicians from their patients were made on each sample. The specimens consisted of 222 from known syphilitics and 115 from normal, non-syphilitic individuals. Of those from syphilitics, 219 were examined in the Bureau of Laboratories by both complement-fixation and Kline exclusion tests and 218 by the Hinton test. Of those from non-syphilitics, 114 were examined in the Bureau of Laboratories by the Kline exclusion; 113 by the complement-fixation; and 110 by the Hinton test.

Following is a summary of the 222 specimens from syphilitics according to stage of the disease:

Stage of Disease	*Number of Specimens*
Primary	0
Secondary	4
Tertiary	26*
Congential	7**
Neurosyphilis	27*
Early latent	51
Latent	109**
Total	222***

The number of early latent and latent cases combined constituted about 75% of the total number. This may be compared with a proportion of less than 40% latent cases in the 1938 series. It seems that the Committee is stressing more and more the ability of a laboratory to detect clinically obscure syphilis and asymptomatic cases.

Specificity of Test

Complement-Fixation Tests — The control laboratories (those of Dr. Kolmer and Dr. Eagle) both obtained 100% specificity. A group of 14 state laboratories entered a Kolmer test but only eight (57.1%) obtained 100% specificity. The other six ranged in specificity between 96.6% and 99.1%. Three state laboratories entered an Eagle test and two (66.7%) obtained complete specificity. The other was rated at 94.7% specificity.

Nine state laboratories entered complement fixation tests not conforming to the Kolmer or to the Eagle test. Five of these (55.6%), including Connecticut, were rated at 100% specificity. The other four laboratories had specificities ranging from 93.9% to 99.1%.

There seems to be but one conclusion to be drawn from the results in this Study: No single type of complement-fixation test has any claim to a monopoly on specificity, a property seeming to depend to some extent upon proper manipulation and control of any given test embodying proper serological principles.

Hinton Test — The control laboratory (Dr. Hinton's) obtained one false positive with 115 specimens, giving it a specificity rating of 99.1%. Four state laboratories out of five (80%), including Connecticut, obtained specificity ratings of 100% while the fifth laboratory in this group rated 98.2% with two false positives in 113 tests.

Three of the four laboratories bettering Dr. Hinton's specificity also obtained higher sensitivity ratings than the author (positives and doubtfuls combined) but it is not known if these laboratories tested the specimen which Dr. Hinton called positive. That specimen was tested with negative results in the Bureau of Laboratories of this Department.

Kline Exclusion Test — In the 1939 series, not a single laboratory, not even that of Dr. Kline serving as control, was able to attain complete specificity by either the Kline diagnostic or the Kline exclusion test, perhaps because of the type of specimens included in the Series.

The laboratory of Dr. Kline obtained one false positive out of 114 normal specimens, a specificity of 99.1%. The Bureau of Laboratories obtained a false positive on the same specimen, and, in addition, six false doubtful (not positive) reactions in the series of 114, a specificity of 93.8%. The five other state laboratories performing this test had specificity ratings ranging from 85.1% to 99.1%. At the time this test was undertaken in this Bureau, and repeatedly since that time, it has been pointed out that as we make use of this test purely for "screen" purposes we desire to have it set at a point where we obtain from 5-10% false positive findings routinely. No positives secured by the Kline exclusion test in the Bureau of Laboratories are reported to physicians unless the specimen also shows a positive complement-fixation or positive Hinton result.

---

*One case listed as "Tertiary or neurosyphilis."

**One case listed as "Latent or congenital."

***Total compensates for two cases, each listed in two categories.

Sensitivity of Tests

Complement-Fixation Tests — Again the results of this series of tests show no advantage for either the Kolmer or the Eagle test over the technic used in the Bureau of Laboratories which we have long called the Connecticut complement-fixation test. In fact, the results strengthen the impression that the Connecticut test is more efficient than the Eagle test and the equal of the Kolmer test.

When the figures on specimens examined in 1938 and in 1939 in all three laboratories are assembled to show the number of negative tests on known syphilitics, the three tests compare as follows with respect to "false negative" results:

SYPHILITIC SPECIMENS

	Percent Missed		
	Kolmer Test	Eagle Test	Conn. Test
1939 (215 specimens)	16.8	22.8	17.2
1938 (205 specimens)	21.5	22.9	20.5
Total (420 specimens)	19.0	22.9	18.8

It is more and more evident that the end results with the Kolmer and with the Connecticut technic are very similar. The close agreement is even acccentuated by the manner in which the tests failed to agree on 21 specimens out of 420 from syphilitics examined in the two years. Ten of these reacted to the Kolmer test but were negative by the Connecticut technic; eleven were negative by the Kolmer but reacted to the Connecticut test. The fact that this disagreement is only 5% of the total number examined and that almost exactly one-half the number of disagreeing tests "fell on either side of the fence" suggests a common factor of error which may well be within the limits of precision of measurement of quantities.

Among 15 state laboratories with 100% specificity, Connecticut stood third in sensitivity. One of the two laboratories with higher sensitivity ratings used a Kolmer test; the other, like our own technic, was a special test, not conforming to any published method.

A word about anticomplementary reactions seems necessary. Only six of the group of 15 state laboratories mentioned above were free from anticomplementary reactions; Connecticut among these six. A test that tends to avoid anticomplementary reactions is greatly to be desired.

Hinton Test — A comparison of results in the Bureau of Laboratories with results in Dr. Hinton's laboratory on 216 specimens from syphilitics actually examined in both laboratories follows:

	Specimens Examined	*Specimens Positive and Doubtful*	*Sensitivity Rating*
Dr. Hinton	216	191	88.4%
Bureau of Laboratories	216	188	87.0%

Although the disagreement is not striking, there appears upon further analysis to be a trend toward under-reading the Hinton test in the Bureau of Laboratories where 11 specimens were reported doubtful which Dr. Hinton called positive. There is no comparable opposite leaning with other specimens. If this is an error it is on the side of "safety" in the routine diagnosis of syphilis.

A summary of results on specimens examined in both laboratories for the last two series, 1938 and 1939, follows:

	Specimens Examined	Percent Reactors	Percent Positive	Percent Doubtful	Percent Missed
Dr. Hinton	397	86.4	84.1	2.3	13.6
Bureau Laboratories	397	84.9	79.1	5.8	15.1

Kline Exclusion Test — More cases of syphilis were detected by the Kline exclusion test in the Bureau of Laboratories than in Dr. Kline's laboratory. The Committee's ratings were:

	Specimens Examined	Number Positive	Number Doubtful	Number Negative	Percent Missed
Dr. Kline	221	201	2	18	8.1
Bureau of Laboratories	219	201	3	15	6.8

Placed on the basis of the 218 specimens examined in both laboratories these figures become:

	Specimens Examined	Specimens Positive	Specimens Doubtful	Specimens Negative	Percent Missed
Dr. Kline	218	198	2	18	8.3
Bureau of Laboratories	218	200	3	15	6.9

Combining results for the last two years on specimens examined in both laboratories, the following figures are obtained:

	Specimens Examined	Specimens Positive and Doubtful	Specimens Negative	Percent Missed
Dr. Kline	420	379	41	9.8
Bureau of Laboratories	420	383	37	8.8

The 1939 Evaluation Study may be briefly summarized as it affects the three tests routinely carried on in the Bureau of Laboratories. The Kline exclusion test is performing its function of a "screen" test effectively. Changes toward better specificity are desirable but only if this can be accomplished without loss of sensitivity. The Connecticut complement-fixation test is doing an excellent job. Changes that might be made are minor ones and should be directed toward eliminating pro-zone reactions. The Hinton test as performed in the Bureau of Laboratories is highly acceptable but closer agreement in readings with Dr. Hinton seems desirable. Steps will be taken promptly to bring this about.

Proposed State-wide Study

Evaluation studies conducted by the United States Public Health Service and the Committee on Evaluation of Serodiagnostic Tests for Syphilis have given the first opportunity ever offered to state health department laboratories to gauge with some degree of accuracy the quality of work being done in the testing for syphilis. The ratings obtained from year to year will doubtless vary depending upon the types of cases from which specimens are collected for the study. It is hoped that the evaluation studies will be continued annually for the benefit of the serodiagnosis of syphilis as it is carried on day by day in the control laboratory in each of the states.

A part of the program for the control of syphilis which is just coming into its own is the extension of the evaluation studies to local laboratories within the states. A few states have completed such studies and several others have evaluations under way or contemplated.

When the Surgeon General informed Doctor Osborn, State Commissioner of Health, on June 30, 1939, that the Bureau of Laboratories had qualified as satisfactory in accordance with the recommendations of the Committee he called attention that it is now desirable that the tests performed in any local serological laboratory should have satisfactory sensitivity and specificity ratings. Again on September 11, 1939, Doctor Parran wrote to Doctor Osborn inviting the State Department of Health to participate in the 1940 study. He stated:

> "This early invitation is being sent to you in order that you may comply with the Recommendations of the Assembly of Laboratory Directors and Serologists made at Hot Springs National Park, Arkansas, in October, 1938, and begin arrangements for the prosecution of similar studies of efficiency of performance of serologic tests for syphilis in the local laboratories in your State. A reply at your earliest convenience, describing your plans regarding this phase of syphilis control, will be greatly appreciated."

In November, 1939, Doctor Maurice J. Strauss, a member of the Public Health Committee of the State Medical Society, brought to the attention of that committee correspondence from the President of the American Academy of Dermatology and Syphilology urging action on this project be undertaken. Doctor Strauss was delegated to secure further information. Estimated costs were prepared for him and presented on February 28, 1940, before that committee. Under this proposal a state-wide evaluation of laboratories would be undertaken on lines similar to those along which the national surveys have been designed.

Bloods would be collected from both syphilitic and non-syphilitic donors and submitted to participating laboratories. All laboratories in Connecticut performing a test for syphilis would be permitted to participate and would be urged to take part since this survey would offer for the first time to the director of each local laboratory an opportunity to evaluate the work carried on in that laboratory. The carrying out of the project awaits funds. It is thought likely that funds appropriated to the states for venereal disease work under the LaFollette-Bullwinkle Act can be used for this purpose upon application to the Surgeon General of the Public Health Service. It seems very probable that a state-wide survey, available to all local laboratories in Connecticut, will shortly be undertaken.

REFERENCES

1. Mickle, F.L. Evaluation Studies on Serodiagnostic Tests for Syphilis. Jour. Conn. State Med. Soc. February, 1938, 2:88.
2. Borman, E. K. Ratings of the Bureau of Laboratories in the 1938 Evaluation Study. Jour. Conn. State Med. Soc., September, 1939, 3:506.
3. Evaluation of Serodiagnostic Tests for Syphilis. Ven. Dis. Inform. December, 1934, 15: 387 also Jour. A.M.A. Dec. 1, 1934, 103: 1705.
4. The Evaluation of Serodiagnostic Tests for Syphilis in the United States; Report of Results. Ven. Dis. Inform., June, 1938, 16: 189; also Jour. A.M.A. June 8, 1935, 104; 2083.
5. The Efficiency of State and Local Laboratories in the Performance of Serodiagnostic Tests for Syphilis. Ven. Dis. Inform., January, 1937, 18: 4; also Am. Journ. of Public Health, January, 1937, 27;15.
6. A Comparative Study of Serodiagnostric Tests for Syphilis as Performed by Thirty-Nine State Laboratories. Ven. Dis. Inform. Aug. 1937, 18:273.

☆☆

SUGGESTS HOW MALE SEX HORMONE ACTS ON FUNCTIONAL DISORDERS OF WOMEN

Androgen, the male sex hormone, which has been found valuable in the treatment of functional disorders in women, probably acts by partially suppressing the formation and preventing the functioning of the female sex hormone, thus restoring the balance between the two hormones, Samuel H. Geist, M.D., Udall J. Salmon, M.D., J.A. Gaines, M.D., and R.I. Walter, M.D., New York, suggest in *The Journal of the American Medical Association* for April 20.

The authors' explanation is based on their studies of the effect of androgen on women with normal menstrual cycles. They point out that the normal woman secretes significant amounts of androgens as well as estrogens, the female sex hormone, and that a normal balance is usually maintained between the two. As suggested in a previous paper of theirs, the androgens probably modify or restrain the action of the estrogens. The results obtained with androgen in treating painful menstruation and bleeding between periods suggest, they say, that in these conditions there may be some abnormality in the androgen metabolism so that the normal balance may be upset.

In order to study the mechanism of androgen action the New York physicians administered the hormone to twenty-five women with normal menstrual cycles. They found that large doses, when given during the first two weeks of the cycle, suppressed menstruation temporarily, while no such effect was produced by similar amounts given during the latter half of the cycle, after ovulation (the formation and discharge of the ova or eggs into the ovary) had occurred. Thus the authors suggest that the hormone, when administered before ovulation, inhibits the normal stimulation of the ovaries and consequently suppresses ovulation. This suppression in turn inhibits the normal formation of estrogen and progesterone (another female sex hormone).

Large doses of androgen also produce changes in the endometrium (the membrane lining the womb) and the vagina which indicate that the available estrogens in the body have been made inactive. Such masculine traits as hoarseness, abnormal growth of hair, and acne are also brought about by large doses of androgen.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD
Stanley B. Weld, *Editor-in-Chief,* Hartford
Sidney G. Davidson, New Haven
Frank Stafford Jones, Hartford
Charles Mirabile, Hartford
Oliver L. Stringfield, Stamford
Herbert Thoms, New Haven

COUNTY NEWS EDITORS
Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

THE 148TH ANNUAL MEETING

With a registration of over 700 and a program unsurpassed in previous years the 148th annual meeting of the Connecticut State Medical Society has passed into history. Much credit is due to Doctor Creadick and his fellow members of the program committee. Their wisdom evidenced by changes made in the arrangement of the program and by the choice of the panel speakers deserves commendation. To Doctor Worthen and his committee on arrangements every member of the Society is indebted. Except for a few unforeseen mechanical difficulties and the gusto of the enthusiastic visitors to the technical exhibits, the entire program was carried through with a finesse borne of attention to the smallest detail.

We welcome to new tasks in the Society the new president, Arthur B. Landry; the new president-elect, James Douglas Gold; the new vice-presidents, Edward J. Ottenheimer and John F. O'Brien; the new treasurer, Hugh B. Campbell; and the new delegate to the American Medical Association, James Raglan Miller. To Doctor Miller also goes the distinguished honor of succeeding Doctor Gold as chairman of the Council. Doctor Gold has guided the affairs of the Council during his several years of office as chairman with unusual wisdom and fairness and has brought to the Council the prestige of a respected personality. Two new members have been seated in the Council for the coming year, Samuel F. Mullins of Fairfield County and Alfred N. Sweet of Middlesex County. Our Society is growing rapidly in strength and influence and its accomplishments should be a source of pride to all of its members.

DEAN BLAKE

When Doctor Bayne-Jones withdrew from consideration for reappointment as Dean of the Yale School of Medicine the School was faced with a problem that could not be quickly or easily answered. Now comes the announcement that Professor Francis Blake has been named Acting Dean and his appointment will meet with the certain approval of the physicians of Connecticut.

Doctor Blake is a graduate of Dartmouth College and Harvard Medical School and joined the Yale faculty in 1921. He is Sterling Professor of Medicine and physician-in-chief and chairman of the medical board of the New Haven Hospital. His research and contributions in the field of clinical medicine are widely known and include the antitoxin treatment of scarlet fever, pneumonia serum therapy and experimental clinical studies with sulfanilimide, sulfapyridine and related compounds. Doctor Blake is a regent of the American College of Physicians and chairman of the medical fellowship board of the National Research Council and has served as president of the American Association of Immunologists and the American Society for Clinical Medicine.

The State Medical Society has long profited from Doctor Blake's fine and understanding help. He has served as an advisor to the program committee of the Clinical Congress ever since its inception. Last winter during the Society's statewide pneumonia program he filled many speaking engagements and he will be chairman of the Program Committee for the Annual Meeting in 1941.

C. B.

* * * *

THE HEALTH OF OUR CHILDREN

Since the turn of the Century civilization has made great advances in different fields. None has been more striking than the reduction of infant mortality. Forty years ago there were 120 to 150 infant deaths per 1,000 live births in the United States. This figure has declined steadily since then until in 1938 there were only 50 deaths, per 1,000 live births. Connecticut is one of the leading states in this reduction being tied with Nebraska for low place in 1938 with an infant mortality of 36. If it were not for the higher mortalities in the Southern States such as New Mexico with a figure of 109 the record for the whole country would be much better than at present. Many factors have contributed to this reduction. The diminished incidence and death rate of congenital syphilis, typhoid fever, tuberculosis, and other diseases has been important. Particularly, however, the death rate has been influenced by the marked drop in deaths due to diphtheria and more especially diarrhea and its complications.

In Connecticut in 1915 there were 1,112 deaths due to diarrhea or a mortality rate of 90.7 per 100,000 of population. In 1938 these figures had dropped to 60 deaths due to diarrhea in infants under two years of age or a mortality rate of 3.4 per 100,000 of population.

The principal factors in the reduction of diarrhea are improved sanitary conditions and the better, and particularly cleaner, feeding of infants. This in turn has been brought out by a very much improved milk supply and by education of parents in the proper preparation and sterilization of formulas and other food. Pasteurization of milk alone has been a great step in advance and pediatricians throughout the country are hoping for the time when this procedure will be generally required of all milk used. Simplification of formula making, and the sometimes excellent proprietary milk products on the market have also helped greatly to prevent gastro-intestinal upsets and diseases.

Doctor Henry J. Gerstenberger did a great service to humanity by starting the first well baby conference in Cleveland many years ago. Since that time conferences of this sort, to educate parents in the proper kind and proportion of food and prevention of feeding disturbances, have been started all over the United States. They have contributed to the health of infants especially in that group where this type of instruction is most needed, namely those unable to afford regular visits to their physician, as much if not more than any other one measure yet suggested or tried.

The American Association for the Study and Prevention of Infant Mortality, an organization of pediatricians established in 1909, and since disbanded, played a pioneer and major role in the educational campaign regarding proper care and feeding of infants. At the present time and since it came into being in 1930, the Academy of Pediatrics has been working with the Children's Bureau in Washington to further plans for the betterment of the health and prevention of disease in the children of this country. This is being done through committees of the Academy which are advising with the Children's Bureau on the health programs to be started and on how they may be carried out. In each State members of the Academy are working through committees with the health departments in planning and carrying out these programs. In Connecticut some of the results of this work at the present time are over 100 well child conferences in rural districts throughout the state, establishment of facilities for advice and care of expectant mothers, different types of nursing service and dental service in the rural communities, and consulting services in Obstetrics, Pediatrics and Orthopedics in these areas. Other projects are under way and many necessary steps need yet to be taken in this educational and preventive program. There is no reason why infant and child mortality cannot continue to decline in the future as in the past if proper cooperation can be fostered and maintained between all health agencies and the private physician working toward this goal.

J. H. R.

* * * *

TREATMENT OF BACTERIAL ENDOCARDITIS

It was inevitable that the sulphonamide group of drugs should be applied to the treatment of bacterial endocarditis after the brilliant results following their use in other bacterial infections. Although relatively many cases of cure of bacterial endocarditis were reported in the three-year period from 1921-1924, no such experience has occurred since[1] until recently, when sulphanilamide and sulphapyridine became available. Published cases of cure by these drugs are beginning to appear in the literature[2] [3], and it may be said with some reason that an approach to the baffling problem has been made. Even in patients who did not recover, the use of the drugs in treatment has prolonged life and has furnished relief from the drenching sweats, limb pains, and other troublesome symptoms. The hopelessness with which both the physician and the patient's family faced the future in these cases need not now be quite so oppressive; the aimless wandering of patients from doctor to doctor seeking cure may perhaps now cease.

The final victory in the treatment of this dread disease has, however, not yet been won. Obviously, sterilization of the blood stream does not prevent, except in special cases, the continued deposition of fibrin and platelets. The growth of vegetations, and thus the disease, may progress even in the absence of bacterial invasion of the blood stream[4]. In fact, some cases of progressive embolization and death may exhibit sterile vegetations and this has suggested to some observers that the streptococcus viridans may be but a secondary invader in a primary non-infective process. If this were true, it might explain many of the phenomena of bacterial endocarditis and especially why temporary sterilization of the blood with chemical agents does not cure the disease. It would focus our attention to the more deep-seated and fundamental pathology, namely, the cause of the formation of platelet thrombi on damaged valves.

A careful study of the vegetations reveals the remarkable fact that the body is not without its power to heal this pathological process on the valve, since the base of the vegetation does not heal. It is merely on the surface that the vegetation continues to grow by repeated deposition of fresh platelet thrombi. Any procedure, therefore, which would prevent the formation of platelet thrombi should permit the natural healing process to cover the surface with fresh endothelium and remove the conditions for the continuation and progression of the disease. Reasoning in this way and recalling that Best[5] has offered heparin as just such an agent, Kelson and White[6] have treated seven cases of bacterial endocarditis with both sulphapyridine and heparin. The method which they outline in detail is to give sulphapyridine for four weeks, and during the second and third week to administer heparin by constant intravenous drip in sufficient dosage to keep the clotting time at about one hour. The authors point out that two of the patients showed severe reactions to the particular lot of heparin, which was obviously toxic, and two others died before the heparin could have acted, but the other three did take a different lot of the heparin, one for seven and the other two for fourteen days, a period which the authors consider long enough to produce an important effect on thrombus formation. These three patients showed striking improvement and remained free from evidences of the disease for nineteen, eighteen and four weeks respectively, after discontinuance of treatment. While such periods of remission are obviously not very long, they furnish hope of cure which hitherto has not been present.

The authors point out with justice that whatever risk of excessive bleeding incident to embolism that may result with the use of heparin, is really of no consequence in the face of the otherwise hopeless prognosis of the disease.

Obviously, the chances of healing the vegetations would seem best early in the disease, when excrescences are small. This places an obligation upon the profession to make the diagnosis at the earliest possible moment in order to institute therapy as early as possible. Undoubtedly, this will stimulate the profession to be alert for the onset of bacterial endocarditis by familiarizing themselves with the situations in which vegetations might be expected to form, such as rheumatic valvular disease and congenital heart lesions.

It is inevitable that as time goes on further experience will furnish the basis for improving the technique of therapy which Kelson and White have suggested, and it is not beyond reason to expect that more efficient bactericidal agents than sulphapyridine will also be forthcoming. But to be able to cure three out of seven cases of bacterial endocarditis, if only for a period, is an important contribution to the therapy of an otherwise hopeless disease and the method merits more widespread trial in other institutions.

L. H. N.

BIBLIOGRAPHY

1. Capps, J. A.: Subacute Bacterial Endocarditis due to Streptococcus Viridans with Special Reference to Prognosis, Ann. Int. Med., 1939, xiii, 280-294.

2. Futches, P. H., and Scott, V. C.: Four Cases of Gonococcal Endocarditis Treated with Sulphanilamide with Recovery of One, J. H. Hosp. Bulletin, 1939, lxv, 377-391.

3. Spink, W. W., and Crago, F. H.: Evaluation of Sulphanilamide in the Treatment of Patients with Subacute Bacterial Endocarditis, Arch. Int. Med., 1939, lxiv, 228-248.

4. Wright, H. D.: The Bacteriology of Subacute Infective Endocarditis, Jr. Path. and Bact., 1925, xxviii, 541.

5. Best, C. H.: Heparin and Thrombosis, British Med. Jr., 1938, ii, 977-981.

6. Kelson, S. R., and White, P. D.: "A New Method of Treatment of Subacute Bacterial Endocarditis" using Sulphapyridine and Heparin in Combination — preliminary report, J.A.M.A., 1939, cxiii, 1700-1702.

* * * *

THE GOD OF WAR CALLS

The Medical Reserve Corps is calling attention to the reserve commissions available to physicians under 35 years of age and well it may. There still lingers among those of the profession in the next older generation an antipathy to all that reminds of war, whether it be due to memories of French mud, English fog or countless hours of waiting in debarkation ports. The Army must be supplied with adequate medical talent and to this group of younger men it now appeals.

Just what tomorrow holds in store for our nation we cannot foretell but one fact is now assured, we must be prepared, and in that preparation the doctor has a place. Should another epidemic surge across the continents of the world such as visited the United States in the late summer and early autumn of 1918 it would be needlessly tragic to repeat the situation which existed at that time when so many towns and cities suffered from lack of good medical care because the ranks of those practicing at home were thinned to the danger point by war. Some such plan must be evolved in this country as now exists in England where a Central War Committee representing all branches of the medical profession has been set up under governmental plans. To this committee the government refers all questions regarding the supply of medical personnel arising out of the war. It satisfies the demands for this personnel, both for the civil population and for central and local government authorities. Local medical war committees scattered over all England are consulted by the central committee before a practitioner is allocated for national service, thus enabling the maintenance of a sufficient quota at home according to the density of population and proportion of physicians practicing in any area. Specialists are allocated in the same manner, qualifications and experience being investigated before appointment. No practitioner is allocated to the services without his consent.

With the lowering of the mortality rate throughout our nation, it is only to be expected that in the event that the present European war engulfs us in its tide more attention by the Medical Corps will be given to prevention of disease in the Army. New advances in chemotherapy may yield large returns. Canada is planning to give every Canadian soldier wounded in battle an injection of sulphanilamide at the earliest possible moment. Blood transfusions and early closure of wounds will play a major role in the present conflict. Blood banks bid fair to become a standard equipment in base hospitals. Already the entire Canadian army has been inoculated with tetanus toxoid. We find the medical profession and the army medical services of Canada working in close cooperation. As in England, no communities will be stripped of physicians and no physician will be named to important army posts on military qualifications alone. The Medical Corps of the U.S. Army has a full sized task ahead. There should be many trained physicians ready and waiting to accept reserve commissions.

* * * *

PHARMACISTS AND PHYSICIANS COOPERATE IN CONNECTICUT

The Connecticut Pharmaceutical Association has expressed its appreciation to the Connecticut State Medical Society for its friendly and cordial cooperation; to Doctor Creighton Barker for his brilliant address and kind invitation to establish a joint conference committee; to Doctor Barnett Greenhouse for his paper, "A Newer Insulin;" to Doctor John W. Foster for his expression of good will.

Formation of a permanent committee of Connecticut pharmacists to meet with a similar group from the Connecticut State Medical Society was agreed upon by the scientific committee of the Connecticut Pharmaceutical Association at the close of its pharmacy clinic conducted recently at the Connecticut College of Pharmacy.

The decision to name this pharmaceutical committee was in answer to the suggestion made by Dr. Creighton Barker, executive secretary of the Connecticut State Medical Society, in his address at the dinner which concluded a full day of lectures and open discussions. Assurance that pharmacists would cooperate was given by Hugh P. Beirne, secretary of the Connecticut State Pharmacy Commission.

Dr. Barker lauded the scientific committee for its excellent work in preparing the extensive program for the first pharmacy clinic and suggested that the joint committee of the medical and pharmacy groups to be appointed to work together in a study of their mutual problems and requirements.

The Conference Committee appointed by the Connecticut Pharmaceutical Association is as follows:

Hugh P. Bierne, New Haven, Chairman
John J. Dugan, New Haven, Secretary
Louis Bria, Waterbury
I. Samuel Ragatsky, Hartford
John H. James, New London
Doctor Robert L. Swain, New York (honorary)

The State Medical Society's Committee was listed on page 279, May issue.

* * * *

COMING MEETINGS

June 4-6 — National Gastroenterological Association, Annual Convention, Hotel Roosevelt, New York City.

June 4-6 — Medical Society of New Jersey, Annual Meeting, Atlantic City, New Jersey.

June 5-6 — Rhode Island Medical Society, Annual Meeting, Providence, Rhode Island.

June 8-10 — American College of Chest Physicians, Annual Meeting, Biltmore Hotel, New York City.

June 10-14 — American Medical Association, New York City.

June 12 — New England Obstetrical and Gynecological Society, Burlington, Vermont.

June 23-25 — Maine Medical Association, Annual Meeting, Rangeley Lakes, Maine.

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

OFFICERS OF COUNTY ASSOCIATIONS 1940-1941

Fairfield County

President: Berkeley L. Parmelee, M.D., 144 Golden Hill St., Bridgeport

Vice President: Ralph W. Crane, M.D., 50 Glenbrook Road, Stamford

Secretary: J. Grady Booe, M.D., 144 Golden Hill St., Bridgeport

Treasurer: Clifton C. Taylor, M.D., 881 Lafayette St., Bridgeport

Councilor: Samuel F. Mullins, M.D., 116 Main St., Danbury

Hartford County

President: William T. Morrissey, M.D., 55 West Main St., New Britain

Vice President: Thatcher W. Worthen, M.D., 179 Allyn St., Hartford

Secretary: Frank T. Oberg, M.D., 689 Asylum Ave., Hartford

Councilor: Edward J. Whalen, M.D., 750 Main St., Hartford

Litchfield County

President: Roy V. Sanderson, M.D., 570 Main St., Winsted

Vice President: Herbert C. Oelschlegel, M.D., 19 Maiden Lane, Torrington

Secretary: W. Bradford Walker, M.D., Cornwall

Councilor: Charles H. Turkington, M.D., On-The-Green, Litchfield

Middlesex County

President: Carl C. Chase, M.D., 121 Main St., Middletown

Vice President: Harry S. Frank, M.D., 144 Washington St., Middletown

Secretary: Charles Russman, M.D., Connecticut State Hospital, Middletown

Councilor: Alfred N. Sweet, M.D., 50 Crescent St., Middletown

New Haven County

President: J. Harold Root, M.D., 103 North Main St., Waterbury

Vice President: Frederick N. Sperry, M.D., 107 Whitney Ave., New Haven

Secretary: Ralph E. McDonnell, M.D., 158 Whitney Ave., New Haven

Councilor: Thomas P. Murdock, M.D., 147 West Main St., Meriden

New London County

President: Clarence G. Thompson, M.D., 257 Main St., Norwich

Vice President: Hugh F. Lena, M.D., 154 Broad St., New London

Secretary: Carl H. Wies, M.D., 58 Huntington St., New London

Councilor: George H. Gildersleeve, M.D., 310 Main St., Norwich

Tolland County

President: William Schneider, M.D., 34 Union St., Rockville

Vice President: Walter C. Haviland, M.D., Mansfield State Training School and Hospital, Mansfield Depot

Secretary: Francis H. Burke, M.D., 27 Park St., Rockville

Councilor: Charles T. LaMoure, M.D., Mansfield State Training School and Hospital, Mansfield Depot

Windham County

President: Morton Arnold, M.D., 781 Main Main St., Willimantic

Vice President: Morton Chapnick, M.D., 168 Main St., Putnam

Clerk: Ralph L. Gilman, M.D., Storrs

Councilor: Robert C. Paine, M.D., Thompson

The New Councilors

Fairfield County. Samuel F. Mullins of Danbury received his degree in medicine from the New York University and Bellevue Hospital Medical College in 1906. Doctor Mullins is a Fellow of the American College of Surgeons, and the New York Academy of Medicine. He is an Attending Surgeon at the Danbury Hospital and ex-president of the Fairfield County Medical Association.

Middlesex County. Alfred N. Sweet of Middletown graduated in medicine from the University of Maryland in 1918. He is a

Fellow of the American College of Surgeons and Attending Orthopedist at the Middlesex Hospital and was president of the Middlesex County Medical Association in 1934.

New Members April, 1940

Fairfield County (23)

Payson B. Ayres, 10 Old Post Rd., Cos Cob
William F. Bria, 25 Bedford St., Stamford
Paul L. Brooks, 1260 East Main St., Bridgeport
Louis F. Castaldo, 47 Goodsell St., Bridgeport
James J. Cognetta, 366 Atlantic St., Stamford
DeWitt Dominick, 881 Lafayette St., Bridgeport
Wesley F. Fitzpatrick, 85 East Ave., Norwalk
William A. Geer, 881 Lafayette St., Bridgeport
John E. Grigas, 235 Greenwood Ave., Bethel
Robert J. Heafey, 3 Washington St., South Norwalk
Paul Lengyel, 787 Hancock Ave., Bridgeport
Mervyn H. Little, 50 Reef Rd., Fairfield
Olga A. G. Little, 1278 East Main St., Bridgeport
David T. Monahan, 144 Golden Hill St., Bridgeport
Thomas O. Murray, 145 Deer Hill Ave., Danbury
Bernard O. Nemoitin, 3084 Main St., Stamford
Andrew J. Panettieri, 131 Marion St., Bridgeport
Louise D. Larimore, Greenwich Hospital, Greenwich
Sidney L. Penner, 2692 Main St., Stratford
Allan M. Ross, 188 Post Rd., Darien
Lillian E. Shaw, Ituri Towers, Greenwich
Thomas J. Tarasovic, 49 Dover St., Bridgeport
William D. Troy, 3 St. George Ave., Stamford

Hartford County (5)

Norman J. Barker, 55 Elm St., Hartford
Francis S. Buccheri, 419 Main St., New Britain
John L. Cogland, 550 Main St., Hartford
Mario L. Garofalo, St. Francis Hospital, Hartford
Paul W. Tisher, 99 West Main St., New Britain

Litchfield County (1)

Robert Walker, Cornwall

Middlesex County (2)

Christie E. McLeod, 28 Crescent St., Middletown
Henry Sherwood, Durham

New Haven County (23)

Vincent Balletto, 265 Main St., East Haven
Fred C. Barald, 487 Dixwell Ave., New Haven
Max L. Berlowe, 60 Trumbull St., New Haven
Joseph F. Burke, 135 West Main St., Waterbury
Herman S. Cutler, 59 College St., New Haven
Dominic C. D'Ambruoso, 3 Elizabeth St., Derby
Rudolph A. Damiani, 5 Cooke St., Waterbury
Edwin F. Gildea, 333 Cedar St., New Haven
William A. Goodrich, 138 Grove St., Waterbury
Ovilda A. Grenon, 586 Thompson Ave., New Haven
William B. Koufman, 45 Trumbull St., New Haven
Frederick C. LaBrecque, 164 West Main St., Waterbury
Marvin A. Latimer, 129 Whitney Ave., New Haven
William Mendelsohn, 442 Temple St., New Haven
William E. Neff, Jr., Main St., Cheshire
Robert R. Nesbit, 1442 Chapel St., New Haven
Louis A. Parella, Broadway, North Haven
Siegmund Pelz, 26 South Main St., Wallingford
William S. Perham, 58 Trumbull St., New Haven
Edward A. Post, 135 West Main St., Waterbury
Harry Sigel, 37 Sylvan Ave., New Haven
Joseph S. Stygar, 272 Main St., Derby
Edgar W. Warren, 109 College St., New Haven

New London County (4)

Sigmund A. Brahms, 563 Ocean Ave., New London
Charles M. Krinsky, 325 State St., New London
Jack Sabloff, 325 State St., New London
Morris Sulman, 203 Montauk Ave., New London

Tolland County (0)

Windham County (1)

Arthur J. Couture, 19 South Main St., Moosup

THE NEURO-PSYCHIATRIC INSTITUTE OF THE HARTFORD RETREAT REPORT OF BOARD OF MANAGERS TO BOARD OF DIRECTORS

The year just closed has witnessed the starting and completion of more construction than in any other recent year.

In the general program for the reconstruction of the older buildings of the Institute, the rebuilding of South and North Halls was left until the end because of the complexity of the problems involved. The entire interior of Old South Hall has now been demolished and the remaining portion of the building has become a part of a new and modern structure — air conditioned, humidity controlled, soundproofed, with the so-called cold daylight lighting system and containing gymnasium, bowling alley and beauty parlor.

A new hydrotherapy wing was added and, with the help of research engineers, a new type of humidity control developed and an elaborate automatic system of water therapies was installed. The building of the North Hall was on a similar basis with gymnasium, bowling alley, barber shop and water therapies for men.

The success of the indoor swimming pool as a therapeutic agent seemed to urge the construction of an outdoor swimming pool which was finished last spring. At the time it seemed to be somewhat of a new departure for a psychiatric hospital but a single season demonstrated its worth and its use has become an important feature on our program of normality. The continued development and increased importance of shock therapy demanded the construction of a specially equipped air conditioned unit of twenty-five beds exclusively for this form of therapy. It has been used to capacity since its completion.

More planting and landscaping of the campus took place during this year than in any other single period. This included the planting of hundreds of trees, flowering shrubs, the returfing of the golf course, the laying of flagstone walks, remodelling of entrances, installation of fountains and similar beautifications. The improvement in the condition and appearance of the grounds seems to justify the expense incurred.

The period covered by this report concludes one phase of the institution's development which began nine years ago. At that time we were faced with the need for new buildings and for Radical Reconstruction of the old ones and this need was so great that it was decided to go ahead with the work step by step without waiting for a time when general economic conditions might appear to be more favorable. It is fortunate that we did not wait because notwithstanding the adverse general conditions which have prevailed with some fluctuations throughout the entire nine year period the energy and administrative ability of the Psychiatrist-in-Chief, Doctor Burlingame has been sufficient to overcome great difficulties and remodel and reconstruct the plant of the institution.

During this period of nine years, fourteen new buildings or additions to existing buildings have been constructed on the campus, and more than fifty new medical and educational facilities have been added. In addition, every building on the campus has been modernized or rebuilt. The actual construction which has been accomplished in the past nine years far exceeds that in any comparable period of the history of the institution.

There is no necessity to elaborate upon the details of what has been accomplished but the more tangible and important objectives which have been attained are these:

NEW BUILDINGS AND ADDITIONS

Graduate Club
Vauxhall Row
Science Building
Personnel Building
Clovelly Towers
Shock Therapy Unit
Personnel Infirmary
Hospitality Shop
Cone Hall and Tuck Shop
Outdoor Swimming Pool
Hydrotherapy Building
North Hall
South Hall
Terry Hall Additions

REBUILT, MODERNIZED AND REFURNISHED BUILDINGS

10 Cottages for Guests (Patients)
13 Residence Halls for Guests (Patients)
3 Personnel Residences
Physiotherapy Institute
Terry Hall Administration
Entire Center Building
Ives Hall (Main Gymnasium)

Golf House
Rebuilding of Golf Course and Installation of Underground Sprinkler System
Greenhouses
Main Kitchen
General Stores
Artisan Shops
Rebuilding of All Roads, Sidewalks, Entrances, Together with Beautification of Campus
Entire Replacement and Modernization of Water, Gas, Electrical, Heating, Telephone, Interdepartmental Communication Systems

NEW MEDICAL AND SCIENTIFIC SERVICES

Clinical Diagnostic Laboratories
Research Laboratories
Science Library
Scientific Abstracts and Translations
Clinical Psychological Laboratories
Research Psychological Laboratories
Clinics:
  Major Surgical
  Minor Surgical
  Dental
  Gynecological
  Eye, Ear, Nose and Throat
  X-Ray
  Orthopedic
  Neurological
  Cardiac and Chest
  Allergy
  Endocrinology
Medical Therapies:
  Hydrotherapy
  Electrotherapy
  Pyretotherapy
  Mechanicotherapy
  Special Diet Kitchen
Pharmacy
Personnel Health Service

ADDITIONAL NEW AUXILIARY FACILITIES

Indoor Swimming Pool
Squash Racquet Court
5 Gymnasia
3 Bowling Alleys
Billiard Room
Bowling Green
Tennis Courts
3 Outdoor Gymnasia
Outdoor and Indoor Badminton Courts
Circulating Library
Gift Shop
Knitting Shop
2 Barber Shops
2 Beauty Shops
Printing Shops
Horticulture Class Rooms
Outdoor Theater
Indoor Theater
Home Economics Laboratory for Guests (Patients)
Fine Arts Studios
Commercial Art Class Room
Commercial Course Class Room
Manual Arts Class Room
University Extension Class Rooms
Costume Designing Class Rooms
Leather Working Shop
Art Metal Shop
Ceramics Shop
Piano and Voice Studio
Instruction Organ
Establishing Weekly Publication for Guests
Livery and Touring Service for Guests

NEW RELATIONSHIPS

Organization of the Faculty of Instructors for Guests, with Personnel of 60
Creation of a Board of Nursing Advisors
Inaugurating the Following Programs of Instruction:
  a. Postgraduate Instruction for Neurologists and Psychiatrists
  b. Postgraduate Instruction in Psychiatric Nursing
  c. Postgraduate Instruction in Psychology
  d. Post-Collegiate Instruction for Psychiatric Aides
The Development of Research Programs

APPROVALS AND AFFILIATIONS

American College of Surgeons
American Medical Association
Wesleyan University, Middletown, Connecticut
Columbia University, New York City
College of Physicians and Surgeons

Although the foregoing list records a noteworthy performance, it would be a mistake to regard it as a complete record or to assume that the ultimate in development has been attained or that our accommodations are fully adequate to our present needs. Already the Science Library, which is the heart of research and professional growth, has outgrown its quarters. The Research Laboratories, X-ray department, and other scientific facilities already are so cramped that we must plan for a new Science Building in the not too distant future.

The main personnel dining room in the Graduate Club, completed only six years ago, is now called upon to take care of double the number for which it originally was constructed. Unless we stand still scientifically, our need for construction and remodeling will continue to be with us. As long as the Institute progresses, our plant will never be finished.

During the past year the Institute became a one-quarter participant in a half-million dollar trust fund left by Mr. Richmond P. Paine. This comes at a most opportune time. It has always seemed to us that the methods originating here at the Institute were worthy of more universal application and that the Institute offers a fertile field to those who are contemplating endowment to an enduring worthwhile undertaking. Nervous and mental diseases are today the greatest economic and social problem in medicine. Scientific knowledge has increased to a point where it is fair to assume that endowment of free beds or endowment of research at the Institute will extend helpful assistance to those who are now being retired to the side-lines through lack of treatment such as the Institute could provide. The past year has been the most active in the history of the Institute both in point of service to the community and in scientific and educational advancement.

We have again adhered to the policy of living within our income, of doing all that we could with the resources available and incurring no debts.

It is my hope that the future will permit us to make still further progress and that thereby we shall be enabled to contribute still more to the care of the sick and to the advancement of science. Thus the institution should gain and continue to hold a wider recognition of its usefulness to society.

Francis W. Cole
Chairman

Hartford, Conn.
April 29, 1940

☆☆

THE AMERICAN MEDICAL ASSOCIATION NEW HAVEN — 1860

(*Continued from Page 321*)

and inflammable and before the year of his office expired the Civil War had begun. Doctor Ives died in New Haven on October 8, 1861. The American Medical Association, like all other national enterprises, was disrupted by the War between the States, it did not have another convention for three years, the next meeting was in Chicago in 1863.

IMPORTANT NOTICE

The House of Delegates of the State Medical Society on May 23 voted to advise its members that in the matter of certification of trained attendants in physicians' offices the following course be followed:

1. Any such attendants who do not nor intend in the future to hold themselves out to be nurses or trained attendants should not apply for certification.

2. Any such attendants who do now or intend in the future to hold themselves out to be nurses or trained attendants should apply for certification under the waiver before July 1, 1940.

The American Academy of Pediatrics is sponsoring an educational campaign to create a demand for protective examinations on the part of employers and employees. According to the Academy approximately 2% of the teachers actively engaged in elementary and secondary schools in the United States suffer from tuberculosis. The Survey, Jan., 1940.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

-The- General Practitioner's Forum

Extensive injuries of the extremities are being treated by a thorough debridement and immobilization in a plaster cast. Gomez, in the late Spanish Civil War, greatly handicapped by a lack of surgical supplies, was practically forced into following this procedure. His results were so good that he adopted it as a standard form of treatment.

Beekman, at Bellevue Hospital, has been using much the same procedure for about two years with excellent results. Some specific points in his method are as follows:

Avulsions: the skin is cut away from its holding tabs, an assistant then scrapes the subcutaneous fat from it while the surgeon cleans and debrides the wound. After the wound is repaired, the skin is sewed in place and small nicks are made in it for vents. The extremity is then placed in a cast. Unless some factor warrants investigation, the cast is left on for two weeks.

Compound fractures: thorough cleansing and debridement, reduction and immobilization in plaster. This time the cast is left on for six weeks unless untoward symptoms develop.

Only in those cases which are so seriously contaminated that adequate debridement is impossible the wound is left open. Then the procedure is to pack with vaseline gauze and immobilize for two weeks.

One admitted danger in this form of treatment is a gas bacillus infection. At this writing, it still remains to be seen.

One of our reliable scouts reports that hydrocele is being treated by a form of "autoserotherapy." If the fluid drawn from the sac is clear, 19 cc. of it is injected in the patient's buttock. Rarely is more than one treatment needed. As it comes from a large urological service it sounds interesting and is worth trying.

Dudley J. Morton of the Columbia Medical Center has done a great deal of pioneering research on the development and mechanics of the foot. In a recent talk and reiterated in a personal communication, he stated that 90% of all foot troubles can and should be treated by the family doctor. Some interesting and specific highlights in his paper are as follows:

1. So called orthopedic shoes and devices are a waste of money and do not meet anatomical needs.

2. Anthropological and mechanical studies show that there is no metatarsal arch in the foot.

3. That painful feet and subsequent painful hips and backs are due to improper distribution of the weight bearing on the feet. This due to an anatomical fault of the first metatarsal.

4. The first metatarsal carries the main load in the foot. If it is short the second metatarsal is usually thickened and longer and the distribution of the load becomes faulty with consequent symptoms. An associated finding is extreme motility of the joint between the first and second cuneiforms.

His recommendations for relief were simple and direct:

1. X-ray all feet in weight bearing position.

2. Wear well made, comfortably fitted shoes during hours of greatest use.

3. If anatomical fault is demonstrated, wear an inner sole with an uplift wedge under the short first metatarsal.

For tired, aching feet he recommends contrast soaks.

Oxygen has been used in many conditions. Recent papers have stressed its value in the relief of migraine, prevention of post-operative pneumonia and shock. Now Boland, J.A.M.A., April 20, 1940, advocates its use for the relief of pain in coronary thrombosis and angina pectoris. T. P. R. M.D.

* * *

One of the needs for the control of tuberculosis today is for greater emphasis on the extent of the disease and less on its declining death rate. Rice, John L., M.D., N.Y. City Dept. of Health.

Our Neighbors

MASSACHUSETTS

The Associated Hospital Service Corporation better known as the Blue Cross of Massachusetts, reports a surplus of $152,359.73 for the year 1939 against a deficit of $7252.84 at the beginning of that year. Over 76 percent of earned income was paid out for hospital service to subscribers during the year. General operating charges amounted to 8.7 percent and the cost of acquiring new members, servicing accounts and conducting a public education program was 2.5 percent, making a total of 11.2 percent of earned income spent for administration and operation.

* * * *

NEW YORK

The 1940 New York State Legislature passed the Mahoney-Miller Act making a year's internship obligatory in that state. It also enacted two measures, endorsed by the profession, permitting qualified practitioners from outside the state to be licensed without examination and authorizing graduates of acceptable schools elsewhere to practice in hospitals here. The Legislature passed the Goldberg bill, insinuating a health insurance feature into the State Unemployment Insurance Act. This was apparently due to failure to recognize the full implications of the measure, viz., compulsory health insurance incognito. This bill was later vetoed by Governor Lehman.

New York has a summer camp for underprivileged diabetic children started in 1936 by the New York Diabetes Association. The success of the undertaking is proven by the fact that in 1939 there were forty applications filed by former campers. In spite of the short stay of the individual camper the general condition of a large proportion of the children was improved and a better diabetic balance was obtained in over two-thirds of them. Without detracting from the recreational status of the camp, instruction in urine testing, insulin injections, and food value estimations were given so that every child on leaving was able to test its own urine, inject its own insulin, and make simple substitutions in its diet. It was found that the height and weight of the children on arrival at camp compared favorably with normal standards, the frequency of glycosuria increased progressively each year, but with the increase in the use of protamine zinc insulin and the increase in the carbohydrate content of the diet the positive acetone tests became less frequent in both an actual and a relative number.

- NEWS -

from County Associations

Fairfield

On May 7, Doctor J. Russell Twiss, Assistant Professor of Medicine at Columbia University, addressed the Bridgeport Medical Association. Dr. Twiss began with the statement that some years ago a hospital with which he is associated made a follow-up study of patients upon whom a cholecystectomy had been done, with the remarkable finding that over sixty percent of these patients returned with the original complaint for which they had been operated. He then proceeded to the presentation of his subject, "Recent Developments in the Medical Management of Gall Bladder Disease," which he gave in a concise but comprehensive manner. He ended by presenting the criteria for surgical treatment of the gall bladder and was rewarded by full discussion both from the medical and surgical viewpoint.

On May 14, a combined County-Local Medical meeting was held at the Pickwick Arms Hotel in Greenwich with the Greenwich Medical Society as host. Doctor Francis G. Blake, Sterling Professor of Medicine at Yale, and recently appointed acting Dean of the Yale Medical School, spoke on "Modern Trends in Chemotherapy." Doctor Blake presented the subject in his usual clear and concise manner, with particular emphasis on sulfanilamide, sulfapyridine, and sulphothiazol.

The Board of Directors of the Stamford Hospital have announced the appointment to the consulting staff of Paul H. Brown, Commissioner of Health for the City of Stamford, and of Harold Gaetz, resident physician of the Laurel Heights Sanitarium at Shelton, Connecticut. Additional appointments include: Newell W. Giles and James J. Costanzo to the Ophthalmological service; Leo Hymovich and Alfred J. Sette to the Assistant Surgical Staff, Robinson H. Dorion and Solomon Friedberg to the Assistant Medical Staff; and William M. W. Rynard as Assistant Anesthetist.

For the June meeting of the Stamford Medical Society the dinner committee has arranged the Annual Mid-Year Dinner and Golf Tournament.

On May 15, the Norwalk Medical Society was addressed by Doctor Ralph Barrett of the Womans Hospital, New York City. Doctor Barrett's subject was "Complications of Late Pregnancy."

On May 12, the Annual Bridgeport Hospital Day Service was held in the United Church, with the Directors, the Medical Staff and the Nurses of the hospital attending in a body.

* * * *

Hartford

Doctor William P. Murphy, Senior Assistant in Medicine at the Peter Bent Brigham Hospital and Associate in Medicine at Harvard Medical School, Boston, addressed the Hartford Medical Society at its regular meeting on April 15 on "Anemia — A Deficiency Disease." Doctor Murphy illustrated his excellent presentation with colored slides and a colored movie film.

Doctor Warren H. Cole, Professor of Surgery of the University of Illinois and who will be recalled by many for his work with Doctors Graham, Copher and Moore in the development of cholecystography, addressed the Hartford Medical Society on May 6, 1940, on "Acute Pancreatitis and Related Conditions of the Biliary Tract." His talk was augmented by interesting slides. He is in favor of conservative treatment in Acute Pancreatitis particularly of course, in the edematous type. He stressed the value of the newer diagnostic tests, namely, the Urinary Diastase and Blood Lipase.

In the afternoon at 5 P.M. Doctor Cole gave a Clinic at St. Francis Hospital. Two cases were discussed, one, a young male, age 26, with Idiopathic Hypoglycemia who had had a partial Pancreatectomy and with apparently good results eight months after operation. The other patient had a stone in the common duct of the silent type and this allowed Doctor Cole to discuss many features in relation to biliary tract surgery and diagnosis.

It is unfortunate that the Clinics which these guest speakers of the Hartford Medical Society so kindly consent to give are so poorly attended. One does not like to think that so many men consider their medical education nearing completion but the relatively few who seem to consistently attend these Clinics will attest to the fact that it is the minority of physicians apparently who feel that they need continued education. It has been no great effort for the Programme Committee of the Society but we do feel that these Clinics have a definite benefit and that more men should attend. We are positive in stating that we know a great many if not all of us will be benefitted by each and every Clinic given. The Programme Committee is not discouraged and for those who are interested, we wish to emphasize that we will continue to try to have every guest-speaker give a Clinic at one of the Hospitals in Hartford.

His friends will be glad to know that Doctor John F. Lynch is quite well and favorably convalescing after a serious illness.

Doctor James Raglan Miller of Hartford was one of the speakers in the symposium on "Early Recognition of Serious Lesions in Special Fields of Medicine" conducted by the Medical Society of the State of New York at its annual meeting held recently in New York City. Doctor Miller presented the subject as it affected gynecology.

Middlesex

In Bengston-Wood Hall at The Middlesex Hospital on April 8, 1940, was held the monthly meeting of the Central Medical Society. Doctor Carl C. Chase spoke on "Deep Infections of the Neck" with illustrative case reports. The meeting was very well attended and a very interesting discussion followed the presentation by the speaker.

The many friends in Middlesex County of Doctor and Mrs. Chester Waterman are welcoming them back to their new residence in Portland.

The 148th annual meeting of the Middlesex County Association was held at the Edgewood Country Club in Cromwell on April 11. Doctor Thomas H. Lanman from the surgical department of Harvard Medical School gave a most interesting paper entitled "Surgical Problems in Infancy and Childhood." This was felt to be one of the most lucid and informative talks to which the society has listened. The newly elected president is Carl C. Chase and Vice President is Harry S. Frank.

At the Annual Meeting of the New England Society of Psychiatry held at Danvers State Hospital, Hathorne, Massachusetts, on April 25, George A. Elliott, M.D., Assistant Superintendent of the Connecticut State Hospital Middletown, was elected a Councilor.

* * * *

New Haven

Doctor Francis G. Blake, Yale University School of Medicine, presented the latest views on the treatment of pneumonia at the annual meeting of the Massachusetts Medical Society held in Boston in May.

Doctor R. F. Scholl of New Haven is to be one of the speakers at the fifth annual convention of the National Gastroenterological Association to be held in New York City, June 4, 5 and 6.

* *

SULFANILAMIDE AND STREPTOCOCCI

The failure of sulfanilamide to check infection due to two of the several types of streptococcus, some of which have proved susceptible to the drug, is reported in *The Journal of the American Medical Association* for March 9 by Alexander H. Rosenthal, M.D., and Florence M. Stone, Ph.D., Brooklyn, N.Y.

They cite two fatal cases in which sulfanilamide was given for endocarditis complicating pregnancy. The infection in one case was due to group B and in the other to group C hemolytic streptococcus (a microbe capable of dissolving red blood cells). The authors believe that theirs is the first reported case of a fatal infection due to the Group C streptococcus to occur in a human being.

From laboratory experiments which they carried out on the effect of sulfanilamide on both strains of the streptococcus, Doctors Rosenthal and Stone conclude that the drug has little, if any, effect on these streptococci.

* *

REPORT INCREASE INCIDENCE OF CANCER OF RECTUM AMONG YOUNG PERSONS

An increase in the incidence of cancer of the rectum in young persons is reported by Curtice Rosser, M.D., and J. G. Kerr, M.D., Dallas, Texas, in *The Journel of the American Medical Association* for Sept. 23.

They analyzed a series of 100 consecutive cases of rectal cancer and determined the relative incidence of this disease in persons up to 35 years of age, the grade of malignancy present in younger persons as compared with that in older ones and such other factors as might enter into the prognosis of the younger age group.

In the series 2 per cent were 16 years of age, 7 per cent were less than 30 and 17 per cent were less than 36.

The average duration of symptoms for the younger age group was seven months — a period briefer by more than three months than the average duration of symptoms for rectal cancer.

There was no evidence that the grade of malignancy was higher in young than in older persons. The younger group provided better surgical risks, and resection was attempted in a greater number than in older persons.

Neb. State Med. Jour., May 1939

* *

"PLIOFILM," A NEW PROCESS FOR PRESERVING BRAIN SPECIMENS

Doctor L. Wallingford Darrah of Northampton State Hospital, Northampton, Massachusetts, has developed a new technique for the preservation of brain specimens forde monstration and classroom use, or during transportation by airmail, express or in personal luggage. The new process utilizes the Goodyear Tire & Rubber Company's rubber hydrochloride packaging material "Pliofilm." This material is inherently impervious to air, alkali, grease, normal heat and cold, moisture, mold, oil, vermin and water. It also is transparent and can be sealed at high speed with heat alone, either by hand or machine.

The PROFESSIONAL EQUIPMENT Co.
X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS.
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

SPECIAL NOTICES

DEDICATION OF OSLER MEMORIAL TO BE HELD AT BLOCKLEY

The old autopsy house where Osler worked at Blockley has been restored as the Osler Memorial Building, and will be dedicated on the grounds of the Philadelphia General Hospital, at Curie Avenue, near 34th and Pine Streets, Philadelphia, Pa., at 2 P.M. on June 8, 1940.

Original furnishings, including the necropsy table, have been collected. The painting by Dean Cornwell, N.A., of New York, entitled "Osler at Old Blockley," later to be hung in the building will be on exhibition during the celebration.

There are facilities in the building for the housing and preservation of relics of old Blockley, as well as Osleriana. The Committee would welcome any additions to this collection.

A cordial invitation is extended to those who are interested and especially those who are planning to attend the American Medical Association Convention in New York City, June 10th to 14th.

* * * *

A.M.G.A. GOLF TOURNAMENT

The American Medical Golfing Association will hold its twenty-sixth annual tournament at Winged Foot Golf Club, Mamaroneck (Westchester County), New York, on Monday, June 10, 1940. Members may tee off from 7:30 a.m. to 2:00 p.m.

FIFTY TROPHIES AND PRIZES: Thirty-six holes of golf will be played in competition for the fifty trophies and prizes in the eight events. Trophies will be awarded for the Association Championship, thirty-six holes gross, the Will Walter Trophy; the Association Handicap Championship, thirty-six holes net, the Detroit Trophy; Championship Flight, First Gross, thirty-six holes, the St. Louis Trophy; Championship Flight, First Net, thirty-six holes, the President's Trophy; Eighteen Hole Championship, the Golden State Trophy; Eighteen Hole Handicap Championship, the Ben Thomas Trophy, and the Atlantic City Trophy; Maturity Event, limited to Fellows over 60 years of age, the Minneapolis Trophy; and the Oldguard Championship, limited to competition of past-presidents, the Wendell Phillips Trophy. Forty other prizes will be awarded for the various flights.

FELLOWS IN EVERY STATE OF THE UNION: Dr. George Washington Hall of Chicago is President, and Dr. D. H. Houston of Seattle and Dr. Grayson Carroll of St. Louis are Vice-presidents of the AMGA, which was organized in 1915 by Drs. Will Walter, Wendell Phillips and Gene Lewis and now totals 1,565 members representing every state in the Union. The living past-presidents include Drs. Thomas Hubbard of Toledo, Fred Bailey of St. Louis, Robert Moss of LaGrange, Texas, Charlton Wallace of New York, Will Walter of Evanston, Illinois, James Eaves of Oakland, California, D. Chester Brown of Danbury, Connecticut, W. D. Sheldon of Rochester, Minnesota, Walter Schaller of San Francisco, Edwin Zabriskie of New York, Frank A. Kelly of Detroit, John Welsh Croskey of Philadelphia, Homer K. Nicoll of Chicago, Charles Lukens of Toledo, M. M. Cullom of Nashville, W. Albert Cook of Tulsa, Walt P. Conaway of Atlantic City, and E. S. Edgerton of Wichita, Kansas.

DR. JAMES CRAIG JOYNER HEADS NEW YORK GOLF COMMITTEE: The New York Golf Committee is under the chairmanship of Dr. James Craig Joyner, 718 Park Avenue, New York City. He will be assisted by Drs. Edwin Zabriskie, Charlton Wallace, Orrin Sage Wightman and Asa Liggett Lincoln.

TWO 18-HOLE CHAMPIONSHIP COURSES: The twenty-sixth tournament of the American Medical Golfing Association at Winged Foot promises to be a wonderful affair. The club is one of the most elaborate in the country, with a beautiful clubhouse and two sporty courses. The A.M.G.A. officers anticipate that some 250 to 300 medical golfers from all parts of the United States will play 36 holes in New York on June 10th.

APPLICATION FOR MEMBERSHIP: All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A.M.G.A. Write Executive Secretary Bill Burns, 2020 Olds Tower, Lansing, Michigan, for application blank. Participants in the A.M.G.A. tournament are required to present their home club handicap, signed by the club secretary, at the first tee on the day of play. No handicap over 30 is allowed. Only active Fellows of the A.M.G.A. may compete for prizes. *No trophy is awarded to a Fellow who is absent from the annual dinner*, which is always worthwhile waiting for!

* * * *

AMERICAN CONGRESS OF PHYSICAL THERAPY

The 19th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 2, 3, 4, 5, and 6, 1940, at the Hotel Statler, Cleveland, Ohio.

The mornings will be devoted to our annual instruction course, enabling attendance at both the course and scientific sessions which will be given in the afternoons and evenings. This will minimize the time element and permit attendance at both functions during the same week. The seminar and convention proper will be open to physicians and qualified technicians.

Numerous new features will be manifest in the 1940 program. While every phase of physical therapy will be covered in the general program, special emphasis will be laid on the use of physical measures in general practice. Symposia dealing with light, heat and electricity as important therapeutic adjuvants in general medical and surgical practice will appeal to every physician interested in modern therapy.

For information concerning the seminar and preliminary program of the convention proper, address American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

PAN-AMERICAN CONGRESS OF OPHTHALMOLOGY IN CLEVELAND NEXT OCTOBER

Plans for a Pan-American Congress of Ophthalmology to be held at the Hotel Cleveland, Cleveland, Ohio, October 11-12, have been announced.

The congress will be sponsored by the American Academy of Ophthalmology and Otolaryngology, an organization of more than 2,500 specialists in diseases of the eye, ear, nose and throat, which will hold its annual convention immediately preceding the Pan-American gathering.

The U. S. Department of State has expressed its interest and the governments of all the countries of the Western Hemisphere have been invited to send official delegates. It is felt that the meeting will do much toward bringing about an *entente cordiale* among scientific men of the two Americas, and it is expected that a permanent organization will be effected.

The committee that is developing the congress has the following members: Drs. Harry Gradle, Chicago; Conrad Berens, New York, and Moacyr E. Alvaro, Sao Paulo, Brazil. The executive secretary of the American Academy of Ophthalmology and Otolaryngology, which will be host to the Latin-American eye specialists, is Dr. William P. Wherry, 1500 Medical Arts Building, Omaha, Nebraska.

Under the direction of Dr. Berens, papers in Spanish or Portuguese will be made understandable to English speaking ophthalmologists by the use of lantern slides projecting a synopsis of each paragraph translated into English. The reverse process will be used with the English papers. Spanish and Portuguese stenographers will be present to record the discussions in the language of the authors.

The congress is open to any ophthalmologist who wishes to register. Non-members of the Academy of Ophthalmology and Otolaryngology may register regardless of attendance at the Academy meeting proper. Individual invitations have been sent to about 1,800 members of the ophthalmologic profession in the Latin-American countries, as well as to the national societies of eye specialists and the universities. Individual invitations were not sent to ophthalmologists in the United States and Canada, but official invitations to them are being printed in the various journals of ophthalmology. A fee of $5 has been set for membership in the congress.

Among the guests expected for the congress is Dr. Manuel Marquez y Rodriguez, for many years a prominent eye specialist teacher and writer in Madrid and now living in Mexico City.

ABBOTT LABORATORIES FELLOWSHIPS IN CHEMISTRY

For the academic year 1940-41, Abbott Laboratories has established fellowships in several universities with important departments of organic chemistry and biochemistry. The fellowships, carrying stipends of $650 per year, will be available to graduate students in the last or next to last years of graduate work leading to the doctorate degree. The recipients, who are to be selected by the universities in which their work is being done, are not limited as to the subjects on which they will work.

The object of the fellowships is to provide means for the carrying on of additional scientific work in American universities. The future progress of chemical developments in this country will depend upon the availability of well-trained and qualified men, and it is the intent of Abbott Laboratories in establishing these fellowships to lend encouragement in these general fields.

Grants will be made to the following universities:

In organic chemistry:	Cornell
	Harvard
	Illinois
	Michigan
In biochemistry:	California
	Columbia
	Cornell

* * *

Hospital Insurance and Medical Indemnity.

P. Irving M.D., Sec'y Med. Soc. State of N. Y.

First, I would like to stress and stress again the value of keeping medical relief, hospital insurance, and medical indemnity together in your minds as a three part national health program better than any of the others suggested. One great reason that it is better is the retention of continuity of medical service for those who may change their economic levels and on account of unemployment go down into the relief field or, getting jobs, rise to the insurance region. There is no reason why, if these three systems are properly managed, a given individual cannot keep his own doctor or doctors throughout his or her life. And—is not that one form a genuine form of security?

Jour. Indiana State Med. Assoc.
March 1940

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

• Quarto Notes •

INTRODUCTION TO MEDICINE

by

Don C. Sutton, M.D.

Associate Professor of Medicine,

Northwestern University School of Medicine

642 pages $3.25

St. Louis C. V. Mosby Co. 1940

This book presents each disease logically and covers the field of medicine in a thorough and understanding way for student nurses. The diseases are discussed with emphasis on symptoms, latest treatments and nursing care of the patient. The questions at the end of each chapter tend to increase the value of the book for student nurses. The illustrations are complete and up-to-date.

A. McCann

* * * *

CLINICAL ROENTGENOLOGY OF THE ALIMENTARY TRACT

by

Jacob Buckstein, M.D.

Visiting Roentgenologist (Alimentary Tract Division)

Bellevue Hospital, New York City

Consultant in Gastroenterology

Central Islip Hospital

pages $10.00

Philadelphia, Pa. W. B. Saunders Co. 1940

As stated in the preface, the author's aim has been to keep in mind the viewpoint of the specialists in the field of clinical roentgenology of the alimentary tract, — the roentgenologist, gastroenterologist, internist and surgeon, — as well as to afford an authoritative reference for the general private practitioner. A definite attempt has likewise been made to correlate the pathological changes found at operation and at autopsy with the changes produced by such lesions in the roentgenogram. In the opinion of the reviewer, this aim has been accomplished.

For purposes of review, this book can be divided into several parts. Excluding the historical preface, the first sixty pages deal with the normal and diseased esophagus. The roentgen findings in malignancy, ulcer, esophagitis, achalasia, etc., are briefly described and clearly illustrated. Two pages are devoted to the roentgen diagnosis of foreign body and brief mention is made of the importance of the use of barium-containing capsule.

The second portion of the book (223 pages) concerns itself with the normal and diseased stomach and duodenal bulb, and includes an excellent discussion of the post-operative stomach. This, in the reviewer's opinion, is the most valuable section, reflecting the author's wide clinical and roentgenological experience in the Bellevue clinics. The "negative" reproductions, here as elsewhere throughout the volume, are clear and of excellent quality. Proper emphasis has been placed upon the fluoroscopic control of the gastrointestinal examination and observation of the stomach "through every degree of obliquity." The use of mucosal relief studies with an instantaneous change-over device for radiographic confirmation of the fluoroscopic findings is also mentioned. It is clear that this is a valuable adjunct to fluoroscopy and means an improvement in the percentage of correct roentgen diagnoses. The author implies that the reading of gastrointestinal films without proper fluoroscopic guidance is to be condemned. Among the numerous proven illustrative cases which make this section interesting are the clinical, surgical and roentgenological findings in the following: functional spasm of the stomach, chronic gastritis, pyloric stenosis in the adult, phytobezoar, and many other benign, as well as malignant, conditions of the stomach. The discussion of gastric and duodenal ulcer is particularly complete and the various pitfalls of roentgen interpretation are adequately dealt with. Before turning to the section on small intestine, attention should be called to the following statement which appears among the author's seven points in the differential diagnosis between malignant and benign gastric ulcer. "When the niche, even though very large, has a *fluid level capped by air* (in the erect position), one may consider the lesion *benign*. Only with the rarest exceptions, has an ulcer having this appearance ever been found to be malignant."

The part dealing with the small bowel consists of sixty pages. The reason for the paucity of material relating to this important portion of the gut is given by the author as follows: "In spite of the fact that the small intestine is physiologically more important than the stomach or colon, this region has, because of technical difficulties, received less attention, roentgenologically, than either of these two." For small bowel study, Dr. Buckstein apparently abandons the use of fluoroscopic control and advises the following routine: exposure every fifteen minutes for the first hour followed by films at two, three, five, six, nine and twenty four hours. Proper stress is placed upon the variability of the mucosal relief which, as has been shown by Prendergrass, Ravdin, Johnson, and Hodes, differs markedly with the nature of the food ingested. Mention is made of the small bowel pattern in hyperthyroidism and the characteristic appearance of Meckel's diverticulum, retroperitoneal hernia, and that extremely rare entity, primary ulcer of the jejunum. The reviewer is not in entire agreement with the author's contention that the roentgen diagnosis of small bowel obstruction is dependent upon (1) the dilatation of the small intestines and (2) the accumulation of fluid and gas, as other entities will mimic this picture. An important factor in the causation of air and fluid levels, as stressed by Pancoast, is long continued opiate and barbiturate medication, as well as the enteric vascular occlusion, mentioned by the author (Hibbard, Swenson and Levin). Unfortunately no detailed discussion has been included regarding the more recent developments in the use of the Miller-Abbott tube in the diagnosis of complete and partial small bowel obstructions.

The fourth portion of the book dealing with the large intestine (151 pages) is well balanced. Normal findings and congen[illegible]y a discussion of the variou[illegible] and malignant disease. In [illegible] excellent discussion of granulomas and benign tumors of the colon, special emphasis being correctly placed upon the double-contrast method of examination. Noteworthy is the author's differentiation between lymphogranuloma venereum and rectal carcinoma. Absence of anorectal involvement in his experience, even in the presence of a positive Frei test, points strongly to carcinomatous involvement of the rectum.

The fifth and last section of the book (100 pages) concerns itself with herniation and eventration of the diaphragm, gall bladder and bile ducts, and the spleen, liver and pancreas. In reference to the biliary tract, the author feels there is no contraindication to the use of the sodium salt of tetraiodophenolphthalein in the presence of jaundice, and cites evidence to prove that liver damage is not augmented by such a procedure. On the contrary, he feels that important knowledge may be obtained. The illustrations here are likewise excellent. For the gastroenterologist or roentgenologist who desires a thoroughly readable text and a well illustrated book for rapid reference, "Clinical Roentgenology of the Alimentary Tract" can be recommended without hesitation.

G. W. Heublein

* * * *

A TEXTBOOK OF SURGERY

by

John Homans, M.D.

Clinical Professor of Surgery, Harvard Medical School

1272 pages Fifth edition $8.00
Springfield, Ill. Charles C. Thomas 1940

The fifth edition of Dr. Homans' *Textbook of Surgery* includes many changes as well as a few major additions. The latter deals with the use of sulfanilamide in the treatment of streptococcus infections. Also the use of vitamins, externally and internally, is described in connection with wound healing. Vitamin K is advocated for the treatment of bleeding and jaundice. The use of Miller-Abbott tubes for intestinal decompression is described. Advances in local and general anesthesia are enumerated. The use of heparin for the prevention of pulmonary embolus is mentioned. There are many other additions too numerous to mention which keep the subjects up to date.

This book is concise and complete with delightful drawings. It is more than a "textbook" and a valuable adjunct to the office.

B. Dodd

* * * *

ESSENTIALS OF THE DIAGNOSTIC EXAMINATION

by

John B. Youmans, B.A., M.S., M.D.

Associate Professor of Medicine and Director of Postgraduate Instruction,
Vanderbilt University Medical School

417 pages $3.00
New York The Commonwealth Fund 1940

For a period of over ten years Dr. Youmans has been engaged in the instruction of general practitioners in physical and laboratory diagnosis. This present book was written to fill the needs peculiar to such a group. It is concise, limited in its scope, arbitrary but quite readable, and successful in covering the ground intended. The sections on History Taking and Physical Examinations are a little redundant but quite accurate. The discussion of laboratory tests is limited to those procedures of established clinical value which can be carried out in any practitioners office and are still sufficiently inexpensive so that their broad application is feasible. Numerous valuable charts have been appended to the text, illustrating the pathological changes in the cerebrospinal fluid in various diseases, the differential diagnosis of renal disease and an excellent table on jaundice. There are splendid blood plates done in color which portray the common dyscrasias. Most of these are copied from standard texts but a few are original.

This book will have a very limited usefulness but should be very helpful and valuable to the group for whom it was intended.

J. J. Clancy

* * * *

POPULATION, RACE AND EUGENICS

by

Morris Siegal, M.D.

206 pages $3.00
Hamilton, Ontario, Canada — Published by the Author
1939

In this period when pre-marital examinations are being stressed and blood tests required in several of the states, the physician's advice is frequently requested by those contemplating marriage. As a guide for such information Dr. Siegal very ably sets forth some ideas on population and eugenics.

He states that regardless of the views one takes, he cannot overlook facts which are pointing to serious defects in the trend of reproduction. In those groups who are either gifted by nature, or in those who are in a position to create suitable environment for the offspring, the families are very small or there are no families. While in other groups less gifted or otherwise unable to create suitable environment for the young, the families are large. He feels that mankind cannot be expected to go forward in the march of progress when the best individual, the most cultured, the most gifted, those who show success in every endeavor in life, fail in the most vital trust endowed in them — namely, the trust to reproduce their kind.

In a section on negative eugenics he feels that persons should not be allowed to propagate where certain diseases, anomalies and defects are hereditary. He offers as a suggestion in positive eugenics that attempts should be made by means of education, to increase propagation among intellectually endowed people (who in the present times have a tendency to remain celibate) and hereby increase the intelligent population.

He suggests as remedial measures that the housing of cultural people be in homes; that the economic situation be alleviated so that young people can afford a family; that birth control be given to rural sections; that the attitude of marriage be changed to duty from convenience; that gifted children be educated at public expense; that school medical officers give an I.Q. once a year and study the families of those above or below average.

There are 30 pages devoted to building up racial theories, all of which are denied on the last page.

When
Mothers' Milk
is not
available . . .

USE LACTOGEN

It is universally recognized that the milk from the cow is a very satisfactory and successful substitute for mothers' milk if offered in proper form and proportion. That is why Lactogen is made wholly from fresh cows' milk.

Taken from Tuberculin-tested herds, the milk used in Lactogen is completely checked for cleanliness and freshness before acceptance . . . then processed in shining, spotless stainless steel drying chambers under ideal modern conditions of control and sanitation.

Lactogen is fresh, whole cows' milk, fortified with additional milk fat and milk sugar to match human milk proportions of fat, protein, and carbohydrates.

Lactogen is an easily digestibel food. The characteristics of the case in are changed to form fine and flaky curds, and the fat globules are physically broken down.

Lactogen is especially convenient and safe. It may be used even where there is no refrigeration. Its preparation is simple, even for the most inexperienced mother.

No advertising or feeding directions, except to physicians. For free sample and literature, send your professional blank to "Lactogen Department,"

NESTLÉ'S MILK PRODUCTS, INC.
155 EAST 44TH ST., NEW YORK, N. Y.

Rational marriage is the essence of social progress and is necessary for a sound structure. The risks of marriage are personal incompatibility and personal health (T.B., heart trouble, venereal diseases, etc. are mentioned). As a prophylaxis he recommends a physical examination before marriage, a legal certificate of health, a definite type of examination approved by the Ministry of Health, a 30 day time limit after examination, a sworn declaration as to previous health, a fixed fee for examination, with a provision for free examination where necessary. He criticizes the above by questioning the accuracy of the test and wonders if the fear of the test might cause people to resort to common law. The fear of shame at the outcome of the test is likewise a handicap. He feels that the laws should be Federal instead of State.

In order to guard against risks he feels that eugenics and sociology should be taught in high school, and eugenics in relation to heredity in medical schools. Eugenic advisors to young people previous to marriage should be created. Marriage Consultation Bureaus would be advantageous. Birth registration forms should include the age of the parents, their I.Q., physical condition, artistic attainment, associations and public services, physique, stature, previous illnesses and appearance — such as color of hair, eyes and skin. This would supply some family histories, which usually are not known in large cities because of improvements in travel have stimulated migration with resultant change in home environments.

He sums up the sterilization laws of the United States, Germany and other countries and lists the diseases for which sterilization is compulsory. In his general conclusions he feels that 60% of the feebleminded owe their defects to heredity and environment; feels that a doctor who has neglected to take a blood test and as the result of which a child is born with congenital syphilis, should be held for mal-practice; that a great many gynecological operations that have had to be done as sequela to difficult labor (more than 60%) may be avoided if proper judgment is used in planning of labor. A good deal of brain injuries may be avoided by proper obstetrical procedure and good judgment. Alcohol is an anti eugenic agent and people must be warned against this possibility as a cause of feeblemindedness among the normal. He condemns the use of drugs in toxic doses by pregnant women. More than 50% of all mental disorders are the result of environment, pure and simple. Of the remaining 50%, where there exists some evidence of faulty heredity, invironment is also a contributing factor.

He uses the term "carriers" for normal members of the family in whom there exists a greater prevalence of mental defect or disorder than is expected in the general population. Consanguineous marriages in carriers should be discouraged and carriers should not have large families.

He feels that there will probably be many a loving couple who will disregard all warnings and marry in spite of the advice of experts to the contrary. But even when this happens, if the young people are intelligent and enlightened, when it is found that there exists an eugenic risk in the pedigree of one of the partners, they will agree to have no children at all or will agree to limit considerably the size of the family.

Doctor Siegel's complete and concise volume brings a great amount of valuable information to the physician

Indicated for Memorable Moments

It's professional to let your taste prescribe the Scotch of its own choosing... fine-flavoured Johnnie Walker. For there's no finer whisky than Scotch and Johnnie Walker is Scotch at its smooth, mellow best.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820...
Still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE

Wyeth

HAS SHOWN A CONVINCING RECORD* OF EFFECTIVENESS IN ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae • Trichomonas vaginalis
Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

and should be helpful to him in advising newlyweds and regulating families generally.

W. Weissenborn

☆☆

WARNING

Numerous complaints have reached the Registry of Medical Technologists regarding the activities of a Mr. C. A. Bartholomew of Red Bank, New Jersey, who has launched an organization styled the "American Medical Technologists" which purports to issue certificates of qualification. It is soliciting membership especially among graduates of non-approved schools or those who are ineligible for examination by the standards of the Registry.

Bartholomew has never taken the Registry examination but assumes the designation of M.T. after his name in his drive for membership. He has also presumed to give approval to a number of commercial schools which are not approved by the Registry.

This enterprise is not sponsored by any scientific society but appears to be motivated by commercial aspects, as a $5.00 registration fee is solicited from those desiring to join.

To obviate any confusion of this unauthorized movement with the legitimate work of the Registry of Medical Technologists of the American Society of Clinical Pathologists, this warning is issued to all interested in maintaining high standards to disseminate the true information to the unwary about the standing of the so-called "American Medical Technologists."

Amer. Jour. Clin. Path., March 1940

☆☆

THE SPECIALIST IN RUMANIA

The minister of public health and public welfare in Rumania, according to the Journal of the American Medical Association, has elaborated a change in the public health law to the effect that special practice can be pursued only by physicians who can documentarily prove that they obtained their special training in special clinics, in special state institutes or in state laboratories. Before acquiring the title of specialist the candidate has to pass an examination, after having spent the prescribed training years, before special boards. It is of interest to note how similar this law follows the plan of the certifying boards in this country.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1940-1941) . . . 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) . . . 5

ORIGINAL PAPERS:

What Do People Need For Their Health and Medical Care? — Haven Emerson, M.D., New York City 377
Results in Treatment of Epileptics with Sodium Diphenyl Hydantoinate (Dilantin) — Michael E. Brodsky, M.D. et al, Bridgeport, Conn. 385
Placental Blood Bank . . . Samuel Spinner, M.D., New Haven, Conn. 387
Endometriosis . . . Edward A. Herr, M.D., Waterbury, Conn. 389
Renal Function in Adrenal Insufficiency . . Daniel C. Darrow, M.D., New Haven, Conn. 393
Vulvovaginitis in Children — Louis Newton, M.D. and Michael S. Popkin, M.D., Bridgeport, Conn. 395
What Is A Neurosurgical Emergency? . . W. J. German, M.D., New Haven, Conn. 398

ABSTRACT:

Modern Treatment of Pneumonia . . Theodore S. Evans, M.D., New Haven, Conn. 400

EDITORIALS:

Work Beside Work . . . 402
National Health Legislation . . . 402
Doctor Horning Resigns . . . 404
What Others Think About Our Cancer Handbook . . . 405

FROM THE SECRETARY'S OFFICE . . . 407

FROM THE A.M.A. CONVENTION . . . 409

THE DOCTOR'S OFFICE . . . 410

CONNECTICUT HOSPITAL ASSOCIATION . . . 411

SECTION ON ORTHOPEDIC SURGERY . . . 415

SECTION ON INDUSTRIAL HEALTH . . . 417

THE GENERAL PRACTITIONER'S FORUM . . . 417

NEURO-PSYCHIATRIC INSTITUTE OF HARTFORD RETREAT REPORT . . . 418

SIXTEENTH CLINICAL CONGRESS PROGRAM . . . 420

ANNUAL REPORTS OF CONNECTICUT STATE MEDICAL SOCIETY (cont.) . . . 423

OUR NEIGHBORS . . . 427

NEWS FROM COUNTY ASSOCIATIONS . . . 427

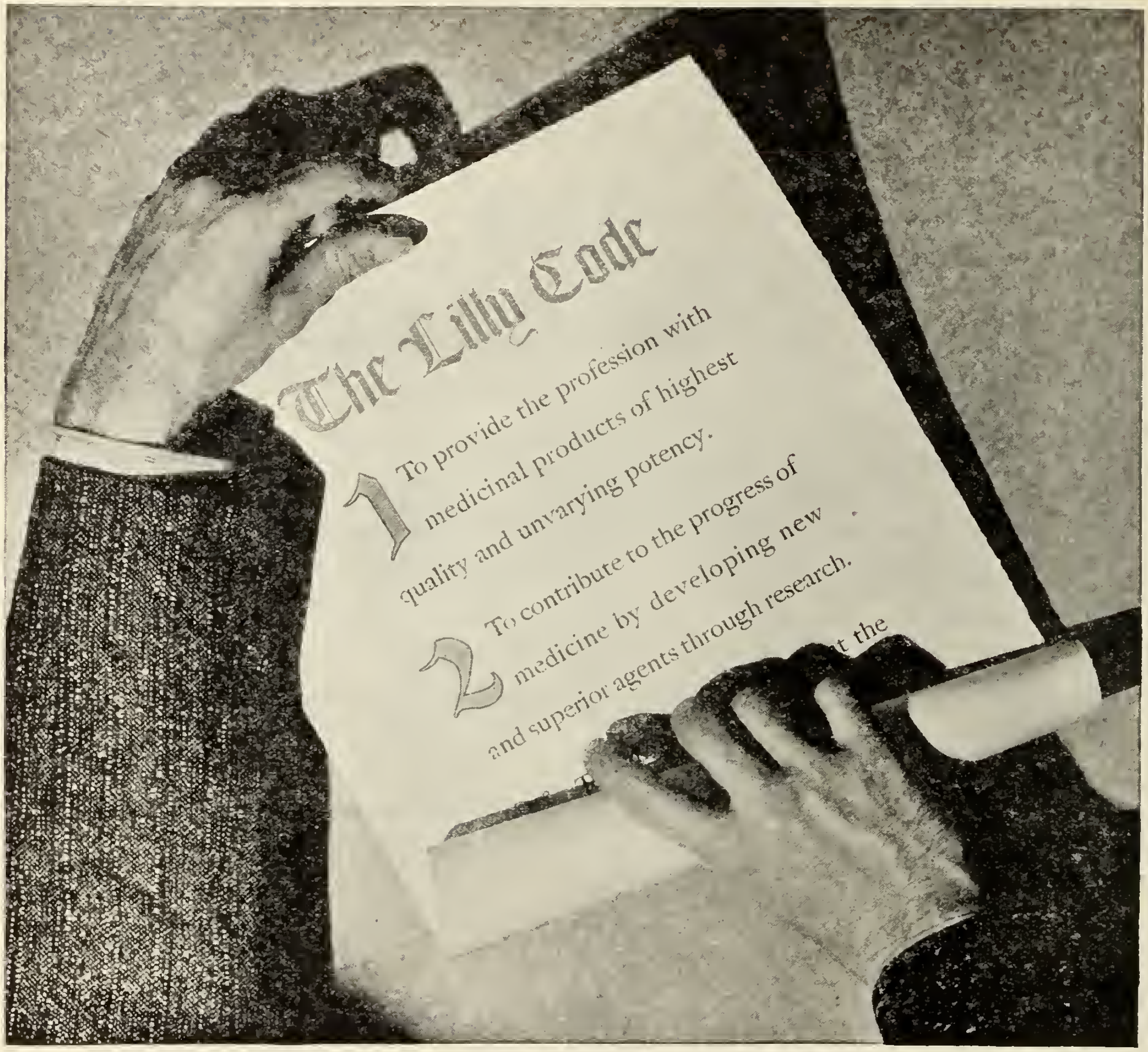
LETTERS TO THE EDITOR . . . 428

SPECIAL NOTICES . . . 431

OBITUARY:

Frank William Hewes, M.D. . . . C.D. Barnum, M.D. 433

QUARTO NOTES (Book Reviews) . . . 433



The Lilly Code

1 To provide the profession with medicinal products of highest quality and unvarying potency.

2 To contribute to the progress of medicine by developing new and superior agents through research.

t the

AMYTAL (Iso-amyl Ethyl Barbituric Acid, Lilly)

SODIUM AMYTAL (Sodium Iso-amyl Ethyl Barbiturate, Lilly)

These are familiar hypnotics in the average medical bag. Long experience has proved them relatively free from afterdepression and moderate in duration of action.

'Amytal' (Iso-amyl Ethyl Barbituric Acid, Lilly) is supplied in 1/8, 1/4, 3/4, and 1 1/2-grain tablets in bottles of 40 and 500.

'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly) is supplied in 1-grain and 3-grain pulvules (filled capsules) and in a number of ampoules to meet emergencies.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

These are your Friends

The Connecticut State Medical Journal

Vol. IV. JULY, 1940 No. 7

What Do People Need For Their Health and Medical Care?*

HAVEN EMERSON, M.D.,
New York City

According to the dictionary a need is a necessity to the Anglo-Saxon, to the German a want, to the Russian a constraint or limitation. To us the needy are persons distressed by want of the means of living. For the medical purpose of the moment we may say that our people need for their health's sake a better quality of, and more equal access to the resources of medicine. It seems to me important that we distinguish in our thinking between *needs*, as we the professional servants of health and sickness measure them objectively, and *wants*, expressed by persons more affected by emotions and personal experience than by scientific training, and for this reason often lacking a just sense of proportion as to the probable results in practice of measures theoretically desirable to satisfy their humanitarian ideals for others.

The ambition of the statesman is matched by that of the physician in that both seek so far as possible the same measure of life and health for the poor as for the rich. This has as yet been nowhere attained, although until recently approached in Scandinavia and Belgium, and may well be the pot of social gold at the end of the humanist's rainbow.

Perhaps man and his invention of government for the ordering of collective existence may be excused some failure to attain a desirable social justice, in not making medical knowledge spread its benefits fairly for all, when we observe how Mother Nature takes such liberties with the arrangement of genes upon which the great variation in the physical and spiritual qualities of man depends.

Medicine is certainly challenged today to deliver better service, and more of it, and at less cost, or accept orders from an insistent public which rightly or wrongly believes that something precious, desirable, necessary and but limitedly available, is being withheld from many of our people because of the selfishness or obstinacy of physicians, for whom the state has created a monopoly in the practice of the healing arts.

This comes as a shock to the professional and ethical self-complacency of physicians, who find to their own manner of thinking a consistent and encouraging record of success towards the goal of sanitarians, and of advances in the accuracy of diagnosis and effectiveness of treatment of disease little short of miraculous.

In the face of the record, with the promise of the future so clearly defined in every sanitary and medical experience of our day, what shall we think of the reasons upon which are based legislative threats and social or political decisions involving the very foundations of medical employment and performance.

I suspect historians will differ in their explanations of the origins of the present conflicting states of social or political and professional opinion. This is not the time or place for prophetic speculation. We are too close to the facts to see clearly or reason with ripe wisdom. There are, however, two features of the past few decades of effort for improvement of health and medical care which may catch the attention of some who follow us. I refer, first, to excessive claims and promises of health, or exaggeration of the results to be expected from preventive medicine, and, secondly, to exploitation of the distresses of the poor for ulterior political and social objectives. There is hardly a movement of popular sanitary reform since 1900 intended to better health in this country, unless it be that for the control of tuberculosis, that has not been guilty of promising benefits beyond the probability of achievement. The pattern of appeals for relief of the needy by agents of private philanthropy has been increasingly adopted by the officers of government, until it would appear today that the person or family not requiring and properly dependent upon public assistance for survival is becoming a rarity, the greatest single block of votes in support of political platforms being created by promises of economic, social and medical benefits from the public till. The extent of the real need for financial relief for a decent subsistence, and of medical services for health protection and in sickness, has been stretched in popular belief to a degree probably beyond the ability of the medical sciences or of the financial resources of the self-supporting fraction of the population to provide, without serious threat to the permanence of our social order or the independence of our immediately following generations.

---

*Read at 148th Annual Meeting, Connecticut State Medical Society, Hartford, May 22-23, 1940.

If one were endowed with true vision, and also vested with plenary powers in the public interest, the following needs would, I believe, be selected somewhat in their sequence of statement as worthy of national effort for the further betterment of health and improvement of medical care of our people:

Need for Better Nutrition

1. There is need of better nutrition to be attained by a wiser and more generous use of essential foods, readily available in abundance and within the means of even modest incomes, and discontinuance of the use of inferior and deleterious or non-nutritious food substances, and abandonment of undesirable practices of food production and processing. This is in part the responsibility of each physician in his private or institutional capacity to remedy, but mainly that of education of the purchasing public, and a duty of government to exercise its authority over commerce in food stuffs. There probably is no greater need in the field of human biology than a better consumer understanding of the relative values and appropriate uses of food.

Need for Education in Human Biology

2. There is need of systematic, balanced and continuous education of children and adults in the facts of human biology upon which intelligent habits of personal hygiene depend. The medical sciences are in command of the more essential facts and are in the best possible position to extend knowledge, particularly upon the management of human reproduction, physical growth and development from birth to maturity, and on the process of normal aging. There is something of enslavement and denial of science and education by political and religious obscurantism that forbids the physicians of Connecticut by archaic laws of the state to give life-saving information to women who wish to control the reproductive function of their own bodies.

Need for Opportunities for Self Support

3. There is need of such economic stability and justice of relationship between employer and employed as will offer the largest practicable fraction of the adult population under seventy years of age opportunity for continuous self-support, including the means to maintain a home suitable for healthy living. This implies ability to meet individually and collectively the costs of medical care for preventive and curative purposes. Such a goal is only in part within the power of any nation to attain alone in a world community so inextricably related internationally as is ours in all matters of production and distribution, finance, communication and natural resources.

A function of government and an obligation of statesmen is to encourage private initiative in industry and commerce so that the potential abilities of all the people can be engaged in the profitable creation of necessities for human subsistence and in satisfying the desires of an expanding culture. Whatever there is of conflict or struggle within industry or of strife for political or financial power of the few over the many, or of interference with capacities for production and services to satisfy the natural demands of people who have the means to pay for these; all such factors in national or international life inevitably hamper and directly interfere with health of the body and spirit of man.

The health of the people of the United States would be more definitely advanced by increase in the profit-earning employment of manpower in industry, commerce and the arts than by expanding considerably the present services of the medical sciences. It is a serious question whether, until useful productive employment is again general for all adult persons able and willing to work, much further continuous progress towards health ideals, theoretically within our reach, can be attained in fact.

Need for Properly Supervised Plans for Medical Care

4. There is need for the creation under permissive state laws and supervision by appropriate officers of government, of financial organizations favoring the development of habits of thrift, among all classes of the community, particularly among wage earners and others of modest means who can put by savings only occasionally and in small amounts. When such legislation is enacted it will appear reasonable and desirable to wage-earners to contribute of their earnings to meet, from such pooled resources of the many, the costs of medical services, both those that are usual and predictable, and such as are rare and may be beyond the means of any but the rich to bear individually and immediately.

It is the duty of the medical profession to pool its experience and put it at the disposal of such prepayment insurance schemes for medical care, so that errors of calculation of cost of medical and associated services and inadequacy of these may be avoided. Physicians and medical institutions must organize the essential personnel and facilities to permit the best quality and range of medical care for the payments available.

Need for Reduction in Costs of Medical Care

5. Our people need and have a right to expect some reduction in the unit costs of indispensable procedures for prevention, diagnosis and treatment of disease, where these can be provided on a mass basis through medical institutions of acceptable standards, whether under governmental, voluntary or proprietary auspices. This is a direct responsibility of the medical profession which as a body will benefit technically and financially from each improvement in the economy and methods of extending the use of necessary medical procedures to a wider public, even if in the process the emoluments of the few who now serve the wealthy in an exquisite manner may be thereby reduced. The potential benefits of extending medical services by lowering costs of essential diagnostic, protective, and even curative procedures without sacrifice of quality have been sampled in but few instances and these usually under pressure from the laity and health administrators.

Need for Postgraduate Training of Physicians

6. There is need of such re-education of physicians periodically during their professional lives as will assure the public of a quality and range of medical care consistent with contemporary advances in knowledge, in skills and in the use of instruments of precision for diagnosis and treatment.

It should be accepted as a present obligation of the medical profession in connection with institutions of higher education to formulate a policy and propose methods of meeting the cost of such post-graduate training, and to assure the public reasonably uniform compliance with the requirements of attendance.

The same privilege which the state accords to qualified persons to enter upon the practice of medicine may be continued throughout life as at present, or it may conceivably be withheld at the pleasure of the state, subject to compliance with further requirements, in response to a need of the public, or because of the rapidity of change in the state of medical progress, or as the rising standards of education for the degree of M.D. seem to demand it.

Need for Proper Distribution of Specialists' Services

7. There is need of such organization and distribution of the services of physicians who possess special knowledge and skills that the optimum use of these for consultative purposes may be possible.

This is a direct obligation upon the medical profession and the medical institutions to which these specialists are attached. The public need and dependence upon experts in diagnosis and treatment of certain types of disease must be met in a way to avoid adverse discrimination against some patients, which now prevails because of their distance from centers of medical service and lack of means to command specialist skills.

Hospital Needs

8. There is need in some parts of our country of such distribution and development of regional or general base hospitals with inclusive services in the full range of medical and surgical specialties, and of subsidiary and related district hospitals with simpler staff, equipment and services, and if necessary emergency or out-post hospitals, as local needs require, to permit access to hospital bed care for all persons whose homes and family resources do not permit of necessary diagnosis and management of their particular sickness otherwise. While the rural hospital unit of small size constitutes an indispensable facility by itself, its value can be greatly enhanced by administrative and professional relationships with a base hospital as part of a state-wide or large city system of hospitals. There is generally throughout the United States a lack of plan and coordination of related institutions and agencies for care of the sick such as is needed to bring the best quality of diagnosis and treatment to the largest number of people at the least cost.

This will require cooperative planning by both government and philanthropy in the interest of continuance and development of the dual system of tax supported and voluntary hospitals which has brought so much success to American hospital building and administration. Initiative in, and achievement of more nearly national hospital coverage may well come from the local and state medical profession, the corresponding departments of health, and regional and national hospital and community welfare associations. Probably to meet hospital needs in some states more state and federal tax funds, will be required for both capital and operating costs, on some such basis as is proposed under the Wagner-George bills now under Congressional consideration.

Need for Home Nursing Care

9. Extension of bedside nursing care to the sick in their homes, in association with private or tax supported home medical care is needed for persons whose home and family conditions permit, and whose illnesses can be as well cared for at home, and perhaps better than in hospitals. Probably no investment by the public in free care for the sick or by the self-supporting sick at home brings such large returns in skilled service, and in helpful and understanding health education as does the employment of visiting nurses under voluntary auspices and professional nursing control as these are at present organized. No less than 30,000 such nurses are needed in addition to the 23,000 now so employed in the United States to carry medical services into people's homes, and probably a total of 65,000 could be used economically and with optimum effect upon national health, especially if physician's care at home for non-paying patients were organized generally as an integral part of the service of an extern staff of the community or district general hospital or otherwise through agreement with the County Medical Society.

Need for Knowledge of Balanced Health Requirements

10. Our people need to be taught what the preventive and curative services are that they should expect to have or are likely to require in the course of an ordinarily healthy life and for the occasions of disease, and when and through what persons or medical institutions these can be had at appropriate cost, or if necessary without expense to the individual patient. The preparation and dissemination of such information should be the responsibility of the medical profession, but not solely. The official health, welfare and educational departments of local government are necessarily involved in the distribution of the facts.

Among the medical services to be particularly and systematically promoted by the official health organization of every community is the procedure of periodic health examination as a basis of health education and personal health guidance of the individual, appropriate to age, sex, occupation, and other determining factors. As a corollary to this, emphasis should be placed upon the case-finding function of the private physician, the essential collaborator with the department of health, as in the discovery of previously undetected cases of tuberculosis, syphilis, cancer, diabetes, malnourishment and other disease conditions of insidious development. The three essential elements of private practice of preventive medicine are periodic health examination at suitable intervals throughout life, systematic case-finding for discovery of diseases widespread but commonly overlooked until well advanced, and application of protective and preventive immunization procedures.

Need for Trained Health Officers

11. Our people need the continuous leadership and direction in every area or population unit of suitable size to meet its cost, of a whole time professionally trained and experienced medical officer of health appointed on qualifications and secure against arbitrary removal during competent performance, and possessing such power over selection of personnel and authorization to spend tax money for specified preventive purposes that the six essential functions of a local health department can be effectively carried out.

Services appropriate to a state department of health should be similarly assured by persons of exceptional administrative competence free from partisan political influence.

Public Health and other medical functions of the federal government exclusive of those appropriate to the Army and Navy should be served within the administrative organization of a single department of bureau with a commissioned officer such as the Surgeon-General of the Public Health Service in charge, whether or not the appointive director of such a service is of cabinet rank.

Need for Protection Against Industrial Hazards

12. If there is one need of health service less adequately met than another and one for which provision in the real sense of the word is either elementary or totally lacking under public authority, it is protection against the environmental hazards of occupied persons, so-called industrial hygiene. Since all occupational disease may be considered properly to be preventable and since detection of early stages of many industrial poisonings is costly and uncertain, and treatment to a great degree is unsuccessful, the size of the problem warrants the inclusion of systematic and universal efforts for its effective control among the health needs of our nation. With the exception of a few states such as Connecticut, and still fewer cities, protection of workers against occupational disease is generally inadequate.

* * * *

It is to my mind questionable whether the contemporary clamor for a larger amount of free and tax supported medical care of the sick among the chronically indigent and those made indigent by sickness alone expresses in fact the first health need of our people. *Until some at least of the items I have listed are provided for, and especially until improved quality of medical care, both public and private, is reasonably well assured by the continuing education of physicians, we should not, it seems to me, undertake the federal socialization of care of the sick with the probability of a widespread and uniform mediocrity of service and a large increase in its cost as a result.*

No mention has been made of the insufficient bed capacity of public institutions for care of mental and tuberculosis patients, nor of delayed provision for cancer clinics and hospitals, nor of many another failure to attain an ideal level of accomplishment, as in the fields of rheumatism, arthritis, diabetes and other chronic conditions. I have refrained from emphasizing the obvious truth that if our people discontinued or merely cut in half their luxury expenditures for alcohol, tobacco, chewing gum, coffee, tea and cosmetics, they would have several times as much money in hand as would have several times cosmetics, they would have several times as much money in hand as would be needed to buy all the health and medical services they can get any benefit from. To teach people to want something they know not of, in place of what social custom persuades them is now desirable, is a challenge to the next generation of educational psychologists, and beyond our present purpose.

What we physicians and sanitarians need, to meet the reasonable expectation of our fellow citizen, is a greater degree of social imagination, ingenuity, and courage to capture the benefits of new resources and techniques of medicine, without loss of the indispensable quality of intimate continuous personal responsibility between physician and patient throughout life.

There is needed among the professional benefactors of their fellow men, the so-called "philanthropoids" of our day, a good measure of patience and critical sense when observing the hesitance of physicians to forsake what they have succeeded in contributing to contemporary society during our own lifetimes, for visions of a Utopia which even now in some other lands has begun to vanish in failure.

Federal Subsidies

The easy American answer of today to all problems of public concern seems to be to pass a law authorizing the federal government to appropriate money to carry on functions on a national scale which the states and local communities have not thought to be of sufficient importance to justify their incurring indebtedness beyond the probable means of our generation to meet out of their own local resources.

It behooves us in the interest of our children and grandchildren and more remote posterity to use our sicence thriftily to save human life and relieve the sufferings of the sick, without at the same time thrusting our successors down into an intolerable economic and political slavery of national and local debt. Until we have led our people locally and by state to so nearly a unanimous way of thinking about the relative values of health and medical care of the sick on the one hand, and other objects of expenditure upon which they now squander colossal sums, without profit or to their obvious disadvantage, it would seem unwise to impose upon them, without their realizing the burden they are assuming, new and heavy costs for medical services which will be lifted, if at all, only by the sacrifices of those who survive us.

Federal subsidies offered to states already possessing much wealth, to the very states from which large resources are withdrawn by federal taxation to permit of aiding impoverished and backward states, constitutes an abuse of the power of taxation and grants-in-aid cloaked by political opportunism. Only where it is clear that there is a serious health or other medical need which is recognized as an unsatisfied want by the people of a particular state or its subdivisions, should national funds be devoted to purely local purposes such as support of departments of health and institutions for care of the sick.

Unless we lack honest conviction in our ability to reduce preventable disease and death, public health services will grow and agencies for relief will diminish in importance. Pestilence in its broad sense of widespread disease among groups, and famine whether as a national catastrophe or as subclinical avitaminoses, remain as they have been since man's earliest social history his greatest enemies in a biological sense.

Among the serious barriers to our achieving the visible goals of medicine is the obvious fact that the best medical care is now so costly that many of our people cannot buy it individually, and when attempts are made to provide it at even a low level of performance through collective resources, by voluntary association or by legal and administrative compulsion, the actual cost becomes enormously increased, largely because of abuses developed by human selfishness, lack of understanding, and by the inefficiencies of public administration.

The effective criticism of the Wagner National Health Bill (S 1620) by a wide variety of competent professional groups seems to have persuaded some at least of its promoters to abandon its most undesirable, visionary and extravagant features in favor of what sounds like a reasonably good proposal for federal aid for the building of rural and regional hospitals as expressed in the Wagner-George Bill.

If the professions concerned are permitted to develop and retain a guiding hand over the quality of medical and associated service, and are ready to exert effective influence towards reduction of unit costs of indispensable procedures for diagnosis, treatment and prevention, we can best lend our influence and urge the public to extend voluntary prepayment plans as most nearly satisfying the tradition, inclination and adaptability of American initiative within the structure of permissive insurance law.

* * * *

Throughout the past century the ambitions of men and women of the medical and associated professions, sensitive to inequalities of opportunity and natural endowment among their fellows, have been focused upon the twin problems of poverty and disease, while industry and commerce have been striving to keep pace with the discoveries of science and the expanding demands for a higher standard of living.

The problems of poverty and disease have been inseparable throughout human history, at one time famine, at another pestilence being the chief cause of racial or national catastrophe. Poverty never occurs without creating disease, disease rarely exists without causing some impoverishment. The two giant forces of the medical and social sciences have vied with each other in attempts to reduce both these major human calamities to a minimum. It has been the good fortune of medicine that in its hands during the past century have been placed the enormous resources of the exact science of biology, while the world still waits information and proof upon which the practitioners of sociology and economics can base sound theory and effective action. Nothing comparable to the advances in individual and collective use of the medical sciences for control of diseases has come from the practical application of the theories of sociologists and economists for the amelioration of poverty. And yet these latter, with their powerful appeal to political forces by promises of economic Utopias and social panaceas, demand a management of medicine for the purpose of controlling a poverty due in large measure to social injustice and economic disadvantage.

Progress in National Health

We have been told by the most persuasive, pervading, threatening and complaining voices of federal authority within the last few years that the national health is in a bad way, that the medical care of one-third of the people is neglected or entirely lacking, that a revolution in the conduct of medical affairs is required, with financial and administrative dependence for health and medical care of every state upon federal authority.

Evidence does not confirm the charge either of neglect of preventive medicine in our country or of any such great amount of illness untreated. Furthermore, in federal statements there is hardly a mention of, and but insignificant emphasis upon the remarkable record of progress which has been continuing for so many years, and in particular since 1929. At least half the story, and that the encouraging side, has been so ignored as to justify the claim that what has been said federally of national health has been biased, has lacked entire honesty and fair sense of proportion, smacks of the nature of propaganda, and has been intended to create an undue sense of public alarm and a political demand for change.

We should rather give attention to the remarkable reduction in the loss of life from diseases known to be practically preventable, an experience of special significance in these past ten years of economic and social confusion and disturbance, when if at all any failure in health protection should have become evident. The record which I offer you has been the product of a medical and social conduct of public health services which should be continued. During the past decade the following significant changes have occurred:

Infant mortality has fallen 46% in New York City and 29% in the United States.

Maternal mortality has fallen 50% or more in most parts of the United States.

The tuberculosis death rate has fallen 43% in New York City and 32% in the United States.

The diphtheria death rate has fallen 97% in New York City and 59% in the United States.

The typhoid fever death rate has fallen 70% in New York City and 59% in the United States.

The death rate from diarrhea and enteritis under two years of age has fallen 62% in New York City and 67% in the United States.

The pneumonia death rate has fallen 66% in New York City and 31% in the United States.

The accident death rate has fallen 39% in New York City and 28% in the United States.

The death rates from three causes, which in the main are *not preventable*, but are typically related to the steadily rising average age of the population, and particularly that portion over 45 years of age, have increased, for diabetes, 36% in New York City and 25% in the United States; for heart disease, 10% in New York City and 22% in the United States; for cancer, 18% in New York City and 19% in the United States.

Death rates for many other diseases have fallen, not as a result of specific measures of prevention so much as from a general rising level of sanitation and personal hygiene, and as a result of improved skills in medical and nursing management of sickness.

No comparable experience can be quoted for any other people or nation in human history. There is nothing in this record to give any basis for the fantastic and exaggerated statements of gloom and despair which were foisted upon the public at Washington in July, 1938, by spokesmen of the federal government, to prepare the voters and the legislators to welcome a vast program of expenditure in the name of health.

The story of improving national health is too consistent and continuous to justify any serious credence in the much exploited claim that more then a third of the nation lacks adequate medical care and that an even larger fraction is suffering from economic disadvantage on account of illness.

In spite of the inadequate incomes of the families of many wage earners, and of the large amount of unemployment, the health of the people of the United States has not been neglected or medical care been denied them.

* * *

If the same close and effective collaboration between communities, their local government and the professions concerned with health and medical care, which have characterized the pattern of life in the United States for the last half century, and the past decade, are allowed to continue without interruption by ill-conceived proposals of government or by the Utopian ambitions of irresponsible groups of social evangelists, further progress of the same character and of only slightly less volume can be assured in the decades ahead, even if we should have no additions to the resources of the medical sciences.

We are, however, in fact in the midst of most aggressive and substantial advances upon all medical fronts of prevention, diagnosis and treatment of disease, and can look forward with entire confidence towards such benefits from these as were not dreamed of at the beginning of the century.

Better care of the sick, better distribution of medical services, thriftier methods of paying for care, benefits from improved techniques of case-finding and early diagnosis, can all be promised with assurance by a continuance of the evolutionary processes which have been found desirable by our society, practicable under the laws, and acceptable by the professions concerned and responsible.

There is residual disease which demands new methods to reach and prevent or treat. The poor now, as in all past times have more sickness and receive less medical care in proportion to their needs than do the self-supporting and well-to-do. There are less physicians living among scattered, economically backward, educationally and culturally disadvantaged people of rural areas, in proportion to the need of medical care than are attracted to the centers of wealth, science and opportunity. There is hardly to be found a person or a family, not excluding those of physicians, where all the helpful medical services are in fact availed of for prevention, or are used at just the right stage of illness or disability to bring the greatest comfort, usefulness and length of life.

* * *

The obvious task facing the nation is to develop trained personnel, and tax resources not out of proportion to the means of the respective units of government to bear, so that every county or group of counties of suitable population size may have at least the standard health facilities which have made the progress and increasing safety of cities possible.

This should be well within our means, either severally by counties at their own expense, or with assistance from the state as a whole or in exceptional cases from Federal government where economically backward, improvident, politically corrupt and incompetent state governments jeopardize the health of their own people and the neighboring states by their neglect.

* * *

Any reasonable persons accessible to the persuasiveness of fact will question the motives, wisdom and experience of those who propose changes in the methods by which government and medicine have built so broad a highroad to our present horizons of national health.

* * *

As a personal belief let me state that, whatever relieves the individual of personal responsibility for his own and his fellows' health; whatever shifts the obligation for the care of the sick from the physician, sought and selected by the patient or the family, into the hands of those impersonally responsible to civil government; whatever permits the neighborhood or community to escape its duty to protect its own people's health by substitution of remote control and resources; whatever tends to magnify the functions and potencies of the State and its man-made laws at the sacrifice of the freedom of conduct of the individual, and of the operation of natural laws; any such threatened changes in our ways of life would, I believe, delay progress towards better health on this continent, and conflict with those precious and enduring qualities of social existence among men and women of good will and common sense which we fondly believe are characteristic of an American philosophy of persons and of our form of representative government.

Results in the Treatment of Epileptics with Sodium Diphenyl Hydantoinate (Dilantin)

MICHAEL E. BRODSKY, M.D., JOHN J. O'NEIL, M.D., and ELMO ZSIGA, M.D.,
Bridgeport, Conn.

Following a dissertation by Merritt and Putman[1] on the use of the above drug in epilepsy, we decided to use the drug in our clinic practice. Since, however, the drug was not available for clinical trial in such quantities as we needed, one of us (M.E.B.) decided to place certain private patients and cases in a chronic institution on the above drug, and later, also outpatients at St. Vincent's Hospital and clinic patients were used in this study. The work was carried out under his supervision with various others of the group in charge of separate clinics and hospital groups.

To make the study comparative with that used by Merritt and Putman, the following classifications were used: completely relieved, greatly decreased, moderately decreased, and no change. Only patients who did not do well on other forms of treatment were used in our series; and only those are reported who have been under observation for over one year.

Of this series there were 18 from our private practice treated directly by one of us (M.E.B.) there were 8 cases treated in the clinic in charge of another of the writers (E.Z.), there were 12 cases treated at Hillside Home in charge of, the third author (J.J.O'N.). All together there were 38 cases studied. Of this number 13 or 34.2% were completely relieved, 12 or 31.6% were greatly decreased, none in our group were moderately decreased, 9 or 23.6% had no change, 3 or 9% had to be discontinued because of complications, 1 died. Of the 13 cases, 1 was completely relieved, 2 cases showed a symptom which has not been described, both cases showed marked loss of weight, 1 of the patients developed a ravenous appetite, never seemed to be full, and was able to sit down and eat a substantial meal and within a few minutes was hungry again. Notwithstanding this tremendous appetite, the patient continued to lose weight. The other was a young girl who developed gingivitis which improved on cevitamic acid but lost 18 pounds in one year. Neither in this case nor in the other case mentioned, was the loss of weight considered serious enough to discontinue medication.

As stated above, we included in this series only such patients as had not done well on other medication. Therefore, no petit-mals were included in this series. In the three cases in whom the failure or lack of improvement was not due to the medication, but was due to complications, there were 2, (1) a man 34, (2) a girl 13, who developed hypertrophic gingivitis. They were forced to discontinue the drug and we replaced the patient on the original medication, high vitamin diet plus large quantities of cevitamic acid. Both these cases have resumed a normal number of convulsive seizures, but the gingivitis, although better than previously, continues to be a troublesome symptom.

One case developed a scarlatiniform rash shortly after the beginning of treatment and was replaced on the former medication. During the course of the treatment, with the patients consent, the sodium diphenyl hydantoinate was again tried with an immediate return of the rash and the patient was again replaced on the older form of medication.

The death of our series was a very terrifying and an unexpected occurrence, and we feel that it was directly due to the fact that the patient was placed on a new form of medication. A brief description of the condition follows:

J. H., 27 years of age, was under treatment by us a great many years. During that period of time, he was on heavy doses of phenobarbital and bromides but without apparent relief. He suffered not less than 5 to 12 seizures per month which were both of petit-mal and grand-mal type. None of his attacks were preceded by aura and were often followed by emptying of his bladder and bowels. During these attacks, the patient often injured himself, and since his dosage of phenobarbital and bromides was very high, it was decided to try him on dilantin.

Shortly after we began to change over, (this was done gradually so that there would be a reserve of the new drug in the system before we discontinued phenobarbital), the patient developed a status convulsivum and became delirius.

He was hospitalized but we were unable to stop the convulsions and delirium, and he rapidly developed pneumonia and died. We do not feel that the change over was done too rapidly since we had taken a few weeks to complete the change, and he was finally placed on 0.5 of a gram of dilantin.

Summary and Conclusion:

It was noticed in our series of 38 patients, that 13 or 34.2% were completely relieved for a period of over one year, that 12 or 31.6% were greatly decreased, that 9 or 23.6% showed no improvement, 9% had to be discontinued because of the above mentioned complications and one case died, the death being attributed, we believe, to the removal of phenobarbital and bromides.

We feel that the sodium diphenyl hydantoinate is a valuable drug in the treatment of epilepsy, particularly in those types where other more common drugs fail. We encountered 3 cases of gingivitis, 1 case was corrected, 2 cases we were unable to control properly.

2 patients were encountered in whom there was a ravenous increase in appetite, without, however, any noticeable physical changes excepting loss of weight. Prior to submitting this paper for publication, we find that, Dr. Denis Williams of London, lost two cases in status epilepticus while receiving the drug.

Name of Author	Total of Cases	% Completely Relieved	% Greatly Relieved	% Moderately Decreased	% No Change	% Increase	Number of Deaths
Putnam & Merritt	118	58	27	5	10		
Kimball	129	62.7	14.7		22.5		
Blair, Bailey & McGregor	75	39.6	20.6	8.6	6.8	24.1	
Steel & Smith	20	60					
Denis Williams	91	19%	71%	8			2
Our series	38	34.2%	31.6%		23.6		1

REFERENCES

1. Merritt, H. Houston, and Putnam, Tracy J: Sodium Diphenyl Hydantoinate in the treatment of Convulsive Disorders.

2. O. P. Kimball: The treatment of Epilepsy with Sodium Diphenyl Hydantoinate, J.A.M.A., 112:1244 (April 1) 1939.

3. Donald Blair, K. C. Bailey, and J. S. McGregor: Treatment of Epilepsy with Epanutin (Dilantin): The Lancet, No. VII, Vol. II:363-367 (Aug. 12) 1939.

4. John P. Steel and E. Seymour Smith: Epanutin In Epilepsy: The Lancet, No. VII, Vol. II: 367-369 (Aug. 12) 1939.

5. Denis Williams: Treatment of Epilepsy with Sodium Diphenyl Hydantoinate, The Lancet, No. XIII, Vol. II: 678-681 (Sept. 23) 1939.

—☆☆—

Charity at Home

Probably the greatest source of unpleasantness between physicians is possession of patients. For some reason the physician has acquired the feeling that his patient, is his chattel, and if his patient consults another physician, his chattel is stolen, and the battle is on. In squatter sovereignty "possession is nine points of the law," but in medicine possession can be retained only by virtue of the continued confidence of the patient in conscientious, skillful and understanding care. The question of medical ethics is frequently embarrassing to the patient, but regardless of ethics the patient is entitled to consult whatever physician he wishes, and his choice is based on confidence in the integrity and the ability of the indivdual doctor. In the oath of Hippocrates the physician swears by Appollo and Aesculapius to impart a knowledge of the art to disciples. The treatment accorded the young doctor who enters a community does not ordinarily comply with the Hippocratic oath, and charity and kindness do not characterize his reception.

Jour. Iowa State Med. Soc.,
Mar. 1940

Placental Blood Bank*

SAMUEL SPINNER, M.D.,†
New Haven, Conn.

History. The transfusing of blood was practised many centuries ago with frequent resulting mishaps. Increasing knowledge gradually has led to present safe status of blood transfusion. The first great step forward was the discovery of the four blood groups. The second advance was the development of a technic for indirect transfusions, using a chemical substance to prevent clotting. The third advance now lies in the preservation of blood in vitro for transfusion at a later date. There are three possible sources for preserved blood. (1) living adult donors, (2) cadavers, (3) placentae of delivered mothers.

First reports came from Russia [1], [2], [3], [4], and showed that preserved blood was usable.

From Canada came a report by Goodall et al[5] of a method of collecting placental blood, preserving it, and then using it without untoward reaction.

Then Grodberg and Carey[6] reported the satisfactory use of placental blood at the Boston City Hospital.

Recently Gwynn and Alsever[7] have shown that placental blood is a safe and efficient form of blood for use in transfusing patients.

As favorable reports began to appear in the literature about blood banks, it was decided to establish a bank at Grace Hospital.

Procedure and Equipment. 1. Donors: All mothers having negative antepartum blood Wasserman and Kahn tests. Cord blood is also tested, as an added precaution.

2. Equipment: 250 c.c. Erlemmyer flask with gauze plug and paper cap; two test tubes; one glass funnel; 0.375 gms. sodium citrate in 30 c.c. distilled water in each flask. All equipment sterilized and wrapped up in sterile package. Package opened at time of delivery and contents transferred to delivery table by scrub nurse.

3. Preserving fluid: At first we used "Russian preservative," consisting of 100 c.c. of fluid containing . . . essentially 0.5% sodium citrate and enough sodium chloride so that final solution is isotonic. Subsequently we used 0.375 gms. of sodium citrate in 30 c.c. distilled water. The change was made because hemolysis became very marked (with Russian preservative) in a very short time.

Recent articles in literature point to value of (a) adding isotonic glucose to preserving fluid; (b) adding small amount of sulfanilamide to more surely obviate bacterial contamination.

4. Collection: Essentially the same technic as described by Gwynn and Alsever[7].

Records. At icebox two books are kept, one for bank deposits and the second for bank withdrawals.

The scrub nurse is responsible for depositing the blood specimen, properly labelled, in the icebox and for recording the deposit in the deposit book by name, date, and bank number. She also brings the labelled test tube for Wasserman and cross-matching to the laboratory.

The physician giving a transfusion may withdraw specimens of previous reported compatible blood and is responsible for recording the withdrawal in the withdrawal book by name of donor, date of deposit, bank number of specimen, name of recipient, date of withdrawal, and his own signature.

Icebox. The icebox used for the blood is of a type that can maintain a constant temperature of 4° to 6° C. which is just above the freezing point and which has been determined as the optimum temperature for blood preservation. Specimens not used were discarded after sixty days at first, then after thirty days, as it was noted that hemolysis became appreciable after that time.

Typing. Typing of bank specimens has not

---

*Read at the Staff Meeting at Grace Hospital, New Haven, Conn., January 9, 1940.
†Formerly, Medical Resident at Grace Hospital.

been performed as a routine measure.

Cross-Matching. Cross-matching was done by laboratory whenever request was made for bank blood.

Transfusion. Performed exactly as with fresh blood, except that if more than one specimen was to be used, they were not mixed together but one followed the other.

Data. There were 221 specimens deposited in the bank of which 137 were used in giving 72 transfusions to 49 cases.

There were seven reactions noted, an incidence of about 10% which, is an average figure even when using fresh blood [8], [9], [10]. Four of these reactions consisted of a short chill and fever. The other three not only had a thermal reaction but also a transient hemoglobinuria.

The indication for these transfusions were (1) infections (acute or chronic) in forty-one transfusions, (2) hemorrhage in seven transfusions, (3) shock in two transfusions, and (4) anemia in twenty-two transfusions.

Changes Occurring in Preserved Blood. It has been demonstrated by several groups of investigators [9], [11], [12], that changes occur in preserved blood which must modify its use.

In hemorrhage, shock, and anemia preserved blood is as valuable as fresh blood for thirty to one hundred days. However, in the hemorrhagic diseases, e.g., in thrombocytopenia or hypoprothrombinemia, preserved blood loses its value, since both platelet and prothrombin content are reduced markedly within one to three days.

In cases of infection (either acute or chronic) where antibodies and phagocytes are desired, both preserved blood and fresh blood are equally questionable in value, unless the donors have been specifically immunized.

Results. After a careful survey of all the factors involved in running a placental blood bank, we might describe its advantages and disadvantages. The availability and low cost of placental blood in a bank are two advantages which are immediately apparent. However, as disadvantages, we must consider the small amount of blood that is obtained, averaging 100 c.c. for each specimen. This necessitates the use of four or five specimens for a single large transfusion. The second disadvantage has been the difficulty in obtaining as many specimens as the number of deliveries in the hospital would lead one to expect. The third chief disadvantage lies in the necessity for additional personel in the laboratory for typing, cross-matching, and daily care of the blood bank specimens. Ideally, there should be one person whose primary duty it would be to keep the blood bank in good order from day to day.

Conclusions.

1. A blood bank is valuable and safe.
2. Placental blood is only a fair source of supply for a blood bank.

REFERENCES

1. Belenkiy, D.N.: Soviet Khir., 3, 394, 1936; Abstr., J. Am. Med. Assn., 109, 161, 1937.

2. Karavanov, G.G.: Vrach, Delo., 18, 131, 1935; Abstr., J. Am. Med. Assn., 105, 240, 1935.

3. Shamov. W.N.: Lancet, 2, 306, 1937.

4. Yudin, S.S.: Lancet, 2, 361, 1937.

5. Goodall, J.R., Anderson, L.O., Altimas, G.T., and McPhail, F. L.: Surg., Gynec, and Obst., 66, 176, 1938.

6. Grodberg, B.C., and Carey, E.L.: New England J. Med., 219, 471, 1938.

7. Gwynn, C. A. and Alsever, J.B.: Am. J. Med. Sc., 198, 634, 1939.

8. Fox, H.: Penna. Med. J., 43, 49, 1939.

9. Belk, Henry and Rosenstein: Am. J. Med. Sc., 198, 631, 1939.

10. Lundy, J.S. Tuohy, E.B. and Adams R.C.: Proc. Staff Meet. Mayo Clinic, 13, 177, 1938.

11. Rhoads, J.E. and Pauzer, L.M.: J. Am. Med. Assn., 112, 309, 1939.

12. Kolmer, J.A.: Am. J. Med. Sc., 197, 442, 1939.

⁂

COMING MEETINGS

July 24-26 — New England Conference on Tomorrow's Children, Littauer Center, Harvard University, Cambridge, Massachusetts.

October 8-11 — American Public Health Association, Detroit, Mich.

October 10-12 — Association of Military Surgeons of U.S., Cleveland, Ohio.

The PROFESSIONAL EQUIPMENT Co.
EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS
TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

Endometriosis*

EDWARD A. HERR, M.D., F.A.C.S.,
Waterbury, Conn.

I. Definition:

Endometriosis is an abnormal growth of endometrial tissue outside of the uterine cavity. This term was originated by Sampson to clear the confusion of previous terms in literature which were so numerous, such as (1) adenomyoma, (2) adenomyosis, (3) chocolate cyst, (4) hemorrhagic perforating cyst and others, which have been abandoned as misleading and incomplete.

II. History

A. In 1860 Rokitansky first described adenoma as a pathological entity, which now is called endometriosis.

B. Between 1893 and 1896 the works of Von Recklinghausen developed the Embryonic Theory that the origin of endometriosis in the myometrium was from the Wolffian body.

C. This was followed by the Invasion Theory through studies of Cullen (1897) who demonstrated that these invading inlets are directly traceable to the surface mucosa. Cullen definitely proved by serial microscopic slides that there is a communication between the gland spaces of the tumor and the uterine mucosa from which they arise.

In 1896, Ivanoff showed that endometrial elements of adenoma may arise from the peritoneal layer of the uterus. Whether the impetus for this metaplasia is chiefly inflammatory, as Meyer suggests, or whether it is the ovarian hormonal action as Novak believes, is not an established fact, but Novak's theory is now generally accepted.

D. In 1899 Russell reported a case of endometriosis found in the ovary. Following this report many gynecologists and surgeons encountered a similar condition without attributing to these cases any greater significance than that they represented rather rare examples of probable inclusion of Mullerian duct elements in the ovary.

E. It remained for Sampson in his series of articles beginning 1921, to express his view, that endometriosis arises from implantation on the surface of the ovaries, or elsewhere in the pelvis, of bits of uterine mucosa which during menstruation had regurgitated from the uterine cavity through the tubes. He believed that transtubal regurgitation of menstrual flow into the peritoneal cavity to be relatively common, particularly in the presence of retroflexion or myoma of the uterus.

III. Etiology:

Thus the etiology may be summed up in the following theories:

1. *Embryonic* rests from the Wolffian body or the Mullerian duct.
2. *The coelomic or metoplasia* of the pelvic peritoneum stimulated by inflammatory process or by ovarian hormones.
3. *Invasion* in which the uterine musculature is invaded by its endometrial lining.
4. *Implantation* by which regurgitation of menstruation through the tubes spills endometrial cells into the peritoneum.
5. Although there is still much controversy as to the etiological cause nearly all now agree that howevei the endometrial cells obtain their aberrant position the stimulus which caused its development into endometriosis is the action of the ovarian hormone.

IV. Macroscopic Pathology:

A. The gynecologist on opening the abdomen and exposing the pelvic organs finds a small adherent mass in one or both sides of the pelvis, usually attached, quite low down, to the posterior surface of the uterus. On loosening these adhesions, to rotate the adnexa into the field of operation, there is a gush of chocolate colored or rusty looking fluid and this should at once make him think of endometriosis.

On examining the ovary he will find a small cyst with a dark hemorrhagic lining which has been opened in bringing up the adherent adnexa. The cyst may be only a centimeter in diameter, and is rarely larger than a hen's egg. The tube is usually quite normal with patent fimbriated extremity, though it may be surrounded by peritoneal adhesions.

---

*Address of Retiring President, Waterbury Medical Association, read at Annual Meeting, January 11, 1940.

On carefully inspecting, by good light, the depths of the pelvis, he will frequently see a number of rather puckered hemorrhagic areas of dark bluish appearance, in one or both uterosacral ligaments, and similar areas may be seen on the anterior surface of the sigmoid or rectum or else-where in the pelvis. This is a very typical picture.

On the other hand, there are cases in which the pelvis is filled with a "frozen mass", consisting of an adenomyomatous uterus with firmly adherent adnexa and bilateral endometrial cysts and extensive endometrial invasion of the rectal or sigmoid a wall. Further-more the uterus is usually enlarged symmetrically to two or three times its normal size, with tiny cystic areas scattered throughout the muscle wall. These cystic areas are dark-brown, almost purple-mulberry color, and contain *blood* which at the time of menstruation finds its way to the uterine cavity; or if the growth is extra-uterine it enlarges and causes more pain from distention of the miniature uteri.

V. Locations:

Situations where tissue resembling endometrium have been reported to have been found are as follows:

(1) In the uterine wall where the growths may be discrete or diffuse, and (2) outside the uterus where they may be in ovaries, recto-vaginal septum, uterine—ligaments, fallopian tubes, abdominal wall, umbilicus, groin, intestinal wall, bladder wall or the vagina.

VI. Symptoms:

1. *Pain* in lower abdomen is an important and may be the chief symptom and, although not always present, is the most constant symptom. It may be intermittent at first, but later is more or less constant. It is particularly related to the menstrual flow and according to the location of the endometrial tissue in the body, whether in the pelvis, the abdomen, or the back. The location of the pain is influenced markedly by the location of endometriosis as involvement of the uterus gives central pain, of the ovary gives right or left quadrant pain, of the bladder, pubic pain.

2. *Menorrhagia* is present in about 40% of all cases and may be extremely severe, especially where the uterus is involved. This may be present as a prolonged menstruation or as profuse bleeding and at times definite hemorrhage at the period.

3. *Dysmenorrhoea*, of recent origin, not associated with onset of menses at puberty, but appearing in the second or third decade, is perhaps the most significant symptom and is present in nearly 50% of all cases of endometriosis. Frequently it is of severe intensity and often becomes progressively worse. The dysmenorrhoea pain is usually most intense in the region of the endometrial implant and may appear preceding the appearance,' during or following the menses. The pain may be referred to the hypogastric, sacral or illiac regions. (Ovary involvement).

4. *Dyspareunia*, may be an extremely troublesome symptom and cause the patient much pain and mental distress. It is met with, in its most severe form, when the endometriosis involves the structures behind the posterior vaginal fornix.

5. *Sterility* is another important sign, particularly when acquired after the patient had been fertile in earlier years. In Douglas' series (Univ. of Manchester, Eng.) of 100 cases, 40% after having born children were sterile from 5 to 10 years.

6. *Other Symptoms* less frequently complained of are shooting pains in the vagina, pain down one or the other leg, difficult or painful defecation, urinary bladder pain or constipation of a marked degree.

VII. Diagnosis:

At present, a preoperative diagnosis of endometriosis is frequently made. The symptoms, however, vary so much that it is not possible to be correct in a very high percentage of cases.

The factors that, if present, will help most in making a correct diagnosis are: (1) a patient's age of between 25 to 45 (extremes from 22 to 62); (2) dysmenorrhoea of the acquired type; (3) pelvic pain or discomfort often extending to the sacrum, or the rectum or down the thighs, always worse at the time of menstruation; (4) menorrhagia; (5) sterility which may be absolute but more often is relative; and (6) dyspareunia (difficult or painful coitus).

The findings on bimanual pelvic examination vary with any associated pathological condition that may be present, and the extent and location of the endometriosis.

A frequent finding is adhesions causing fixed retroversion of the uterus, with or without recognizable tumor; also, thickening in the adnexal region and tenderness on pressure. In some cases cysts from the size of a hazel-nut to that of an orange develop in the ovaries. Small irregular nodules or thickenings of the rectovaginal septum, or in the cul-de-sac, best felt on rectal examination, are highly suggestive.

VIII. Frequency:

Endometriosis does not occur frequently as a clinical condition, however, it can no longer be regarded as a pathological curiosity. Cullen of Johns Hopkins University reports in 1,283 cases of myoma endometriosis found in 73 cases; MacCarty and Blackman at the Mayo Clinic reported a series of 3,398 cases of fibromyoma in which 211 were instances of endometriosis. Tyrone of New Orleans reported similar statistics in a series of 65 cases. Sampson of Albany reported laparotomies, with endometrial implants in 98. Clark reports 29 cases observed at the St. Francis Hospital and Sedgwick County Hospital from 1931 to 1937. At St. Anthony Hospital in a three year series ending January 1, 1938, Long and Strecker of Oklahoma City found only 14 microscopically proven cases of external endometriosis in 1,453 abdominal pelvic operations.

St. Mary's Hospital, Waterbury, showed a total of 19 cases in a three year period from 1936 to 1939, 10 myometrial or uterus, 8 ovarian, and 1 broad ligament.

Waterbury Hospital showed a total of 32 cases in a five year period from 1933 to 1938, 25 myometrial or uterus, 4 ovarian, 2 pelvic, and 1 round ligament.

IX. Treatment:

Ovarian function is essential to the activity and proliferation of all lesions included under endometriosis. Conversely, cessation of activity and progressive atrophy follow ablation of this function. Exceptions to this sequence of events are rarely encountered. Consequently the principles of treatment must be based primarily on these established facts, whether in the form of surgical intervention or of irradiation. Being essentially a disease of childbearing period in whom ovarian conservation is desirable, the decision as to proper treatment may be a perplexing problem.

Only too often radical measures must be adopted, but most gynecologists agree that, whenever possible, it is wiser to err on the side of conservation, especially during the reproductive period.

A. *Conservative Treatment*: In the group subject to conservative measures fall the small ovarian adenomas that can be readily excised and the small superficial implants that can be destroyed by the cautery.

B. *Radical Treatment*: On the other hand large endometriomas may be so densely adherent to the ovary or uterus that liberation is attended with such damage to one or both that removal of the affected organ is necessary.

Again the ovaries may present minor lesions, or more rarely, be normal, yet extensive endometrial invasion of the rectum, sigmoid or bladder has produced decided impairment of their function. Here again, nothing short of a bilateral oophorectomy will suffice.

In the presence of such invasion excision of the diseased areas is rarely necessary. With the cessation of the ovarian function a gradual regression of the implants occurs; this is a slow process which often requires months.

Since stimulation of endometrial tissue is dependent upon ovarian secretions, accordingly treatment is either radical or conservative, depending upon whether or not active ovarian tissue is left after operation.

Despite the fact that residual ovarian function may lead to activation of ectopic endometrial tissue with rapid increase in symptoms and involvement, we believe that the preservation of maximum ovarian function should be the objective in the treatment of this disease as in all pelvic surgery.

The age factor is a prime factor; under 40 years every effort should be made for the preservation of ovarian tissue, over 40 years this factor is of less importance and radical oophorectomy may be employed.

X. Conclusion:

1. The history of endometriosis has been reviewed up to date.

2. The macroscopic appearance in the abdomen has been described.

3. The etiology with the four different theo-

ries has been discussed, and although there is still controversy as to the etiological factors, the exciting cause due to stimulation by ovarian hormone is generally accepted.

4. The symptoms of endometriosis are reviewed, the most constant of which is pain in the form of acquired dysmenorrhoea. Abnormal bleeding most frequently occurs from the uterus, rectum, bladder, abdominal scars, and umbilicus at the time of menstruation. Tender masses in the pelvis with painful uterus are frequently found.

5. The essential points for diagnosis have been enumerated.

6. Relative frequency of endometriosis in the different hospitals has been recorded by statistics.

7. Conservative treatment is advocated to be followed by irradiation if recurrence of symptoms indicate.

8. Finally, a distinction in classification should be made between internal endometriosis, where it is contained entirely in the uterus, and external endometriosis, where the endometrial tissue is outside the uterus,

BIBLIOGRAPHY

George Crile, Jr., M.D., Endometriosis, A Clinical Study of 37 cases.

Virgil S. Counseller, M.D., Rochester, Minn., Endometriosis, A Clinical and Surgical Review, (From the Division of Surgery, The Mayo Clinic). Reprinted from Amer. Jour. Ob. and Gyn. St. Louis, Vol 36, No. 5, Pages 877-888, November 1938, (Printed in the U.S.A.)

Virgil S. Counseller, M.D., Rochester, Minn., The Clinical Significance of Endometriosis, (From the Division of Surgery, The Mayo Clinic).

Emil Novak, M.D., F.A.C.S., Associate in Clinical Gynecology, Johns Hopkins University Medical Dept.; Visiting Gynecologist, St. Agnes and Bon Secours Hospitals, Baltimore, Maryland; Pelvic Endometriosis and Its Treatment.

Wendell Long, M.D., F.A.C.S., and William E. Strecker, M.D., Oklahoma City, Oklahoma, Endometriosis, Review of Incidence in 1,453 Abdominal Pelvic Operations at St. Anthony Hospital 1935-1937, with Particular Reference to Identification and Treatment.

Curtis H. Tyrone, M.D., New Orleans, Endometriosis, A Clinical Study, Reprinted from the Southern Surgeon, Vol. Iv, PP 345-352, Oct. 1935.

Richard B. Cattell, M.D., and Neil W. Swinton, M.D., Endometriosis, With Particular Reference to Conservative Treatment, N.E. Jour. Med. Vol. 214, No. 8, Feb. 20, 1936.

James C. Masson, M.D., Rochester, Minn., Surgical Significance of Endometriosis, Division of Surgery, The Mayo Clinic, Reprinted from Ann. Surg., 227 South Sixth St., Phil. Penn., Nov. 1935, Copyright, 1935 by J.B. Lippincott Co.

J. Thornwell Witherspoon, M.D., New Orleans, Hormonal Origin of Endometrioma, A Hypothesis, Reprinted from the Arch. Path., Vol. 20, pp. 22-27, July 1935.

Floyd E. Keene, M.D., Robert A. Kimbrough, Jr., M.D., Philadelphia, Endometriosis, A Review Based on the Study of One Hundred and Eighteen cases.

Robert D. Mussey, M.D., Section of Obstetrics and Gynecology, The Mayo Clinic and Winfield L. Butsch, M.D., Fellow in Surgery, The Mayo Foundation, Rochester Minn., Symptoms of Pelvic Endometriosis.

Daniel Dougal, M.C., M.D., F.C.O.G., Manchester, England, (Professor of Obstetrics and Gynecology in the University of Manchester), The Problem of Endometriosis, Am. Jour. Ob. and Gyn., Vol. 35, No. 3, March 1938, American Association of Obstetricians, Gynecologists and Abdominal Surgeons.

Howard C. Clark, M.D., F.A.C.S., Endometriosis, Reprinted with additions, from the Arch. Surg., Vol. 38, p.p. 261-273, Copyright, 1939 by American Medical Association.

FOOD AND DRUG ADMINISTRATION TRANSFERRED TO FEDERAL SECURITY AGENCY

President Roosevelt's Reorganization Plan No. IV became effective June 11. On that day, pursuant to the President's plan, the Food and Drug Administration and its functions, except those relating to the administration of the Insecticide Act of 1910 and the Naval Stores Act, was transferred from the United States Department of Agriculture to the Federal Security Agency. Hereafter the Administration will function as a separate unit under the direction and supervision of the Federal Security Administrator. The chief of the Food and Drug Administration is now known as the Commissioner of Food and Drugs. On the same day St. Elizabeths Hospital, Freedmen's Hospital, Howard University and the Columbia Institution for the Deaf also were transferred to that agency. For years the American Medical Association has recommended, and in its platform it continues to advocate, the establishment of an agency of the Federal government under which shall be coordinated and administered all medical and health functions of the federal government exclusive of these of the Army and Navy. The President's Reorgainzation Plan No. IV and the prior transferal of the United States Public Health Service to the Federal Security Agency would seem to indicate an attempt by the President to gather together under one agency the diverse medical and health functions of the federal government.

J.A.M.A., May 25, 1940

Renal Function in Adrenal Insufficiency*

DANIEL C. DARROW, M.D.,**

New Haven, Conn.

In the serum three types of disturbance which are renal in origin have been recognized, namely, (1) increased concentration of nonprotein nitrogen — that is failure to excrete urea adequately, (2) low concentration of sodium and chloride — that is inability to maintain the normal balance of body water and electrolytes and (3) a tendency to increased concentration of potassium — that is increase in the concentration of an ion which causes cardiac symptoms when it reaches concentrations only two to four times those normally found in the serum. Since animals experimentally subjected to bilateral adrenalectomy show increased susceptibility to the toxic effects of potassium, retention of potassium may be an important aspect of adrenal insufficiency. These disturbances in older terminology would be described as (1) increased excretion of sodium and chloride and (2) retention of potassium and nitrogen,

However, the disturbances need to be explained in modern physiological terms. According to prevailing concepts, urine is formed primarily from a large volume of glomerular filtrate which is modified by the tubular epithelium mainly by reabsorption of many solutes but also by active excretion of some substances. Sodium and chloride, which exert the chief osmotic effect of blood plasma, are largely reabsorbed together with most of the water of the glomerular filtrate. If the sodium concentration in serum is low, normal renal tubules can reabsorb most of the sodium so that the concentration in urine is only a small fraction of that in serum. However, in adrenal insufficiency, the tubules cannot adequately reabsorb sodium as is indicated by the fact that the urinary concentration of sodium approaches that of the serum despite the fact that the concentration of sodium in serum may be abnormally low. This leads to continued loss of body sodium and chloride, and eventually to the disturbances accompanying deficit of these ions, that is, the disturbances accompanying dehydration.

In the case of potassium, the concentration in serum is low, but the intake and amounts to be excreted are fairly large. Hence the renal tubules must be able to produce concentrations of potassium in urine which are many times that of plasma. By feeding potassium chloride to normal animals so as to raise the serum concentration, urinary concentrations as high as 50 to 75 times that of serum may be obtained. However, despite comparable concentrations of potassium in serum, adrenalectomized dogs do not produce urinary concentrations greater than 10 fold that of serum. This explains the tendency to retain potassium.

That cortical hormone is necessary for these two functions of tubular epithelium can be clearly shown by administration of cortical hormone to adrenalectomized dogs. Such animals concentrate urinary potassium to levels approaching that of normal animals and show low concentrations of sodium and chloride in the urine. Furthermore, administration of sodium salts does not correct these defects in tubular function, although the sodium salts may restore the concentration of sodium salts in serum to normal and may enable the body to excrete potassium adequately owing to larger volumes of urine. Although there are probably other defects in tubular function, those involving sodium and potassium are apparently the most important disturbances in renal function that are primarily dependent on lack of cortical hormone.

Nevertheless the loss of sodium and chloride leads to certain secondary nonspecific defects in renal function which are the same as those which may be demonstrated in any disturbances accompanied by large deficit of sodium and chloride. These disturbances are those recognized as occurring in so-called dehydration. When the losses of sodium and chloride lead to diminished volume of extracellular fluids, the rate of glomerular filtration diminishes. This leads to a greater decrease in the urea clearances then the decrease in rate of glomerular filtration. This effect of loss of sodium chloride on the rate of glomerular filtration eventually dominates the picture and not only leads to detention of the urea, but also aggravates the tendency to retention of potassium. This dominant effect of loss of sodium and chloride on renal function is further illustrated by the curative effect of the administration of large amounts of sodium salts. Such a procedure quickly leads to adequate excretion of urea, it slowly enables the body to get rid of excess potassium and, if continued in sufficient amounts, enables the body to maintain an approximately normal balance of water and electrolyte. Although sodium salts enable one to keep adrenalectomized dogs alive practically indefinitely, it must be emphasized that these animals are in a precarious state. While renal function of adrenalectomized animals given large amounts of sodium chloride may be adequate to prevent death from renal failure, disturbances in function of other tissues which occur in adrenal insufficiency remain and explain why such animals cannot be considered truly normal animals.

---

*Read before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

**Department of Pediatrics, Yale University School of Medicine.

We may expect that advance in the knowledge of the use of the cortical hormone will enable physicians not only to restore renal function but also to obtain normal tissue functions throughout the body. Nevertheless, since deficit of sodium chloride plays the dominant role in the renal insufficiency of the terminal stages of adrenal insufficiency, administration of sodium salts will always be a part of the treatment of Addison's disease.

In brief, adrenal insufficiency leads to increased excretion of sodium and diminished excretion of potassium. These defects are explained by disturbances in tubular function. Secondary to the losses of sodium and chloride, the changes in renal function accompanying dehydration develop. These changes are diminution in the rate of glomerular filtration which aggravates the defective excretion of potassium and leads to retention of urea and other substances.

REFERENCE

Harrison, H. E. and Darrow, D.C. Renal Function in Experimental Adrenal Insufficiency. Am. J. Physiol., 125, 631, 1939.

☆☆

NEW QUARTERLY BULLETIN OF THE AMERICAN COMMITTEE ON MATERNAL WELFARE

The American Committee on Maternal Welfare, Inc., has recently issued its first number of a quarterly bulletin entitled "Mother." In this first issue the purposes of the bulletin are thus expressed, "to keep the individual members of the American Committee on Maternal Welfare informed regarding the plans and programs of maternal welfare which are being carried out in the various communities. It is not intended to be a medical journal or to present scientific articles. It is hoped that it may serve as a medium of exchange between medical, nursing, public health, educational, institutional and other groups who are interested and active in the promotion of better and more complete maternal care."

This first issue of the Mother contains a summary of maternal welfare programs, including Connecticut, and also a classification of the toxemias of pregnancy. The American Committee on Maternal Welfare is in earnest and will make its voice heard through this new publication.

The PROFESSIONAL EQUIPMENT Co.
X-RAY
SUPPLY and SERVICE SPECIALISTS.
KELEKET APPARATUS.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

Vulvovaginitis in Children

A Summary of a Series of 59 Cases*

LOUIS NEWTON, M.D., and MICHAEL S. POPKIN, M.D.,
Bridgeport, Conn.

Vulvovaginitis is an inflammation of the mucous membranes of the lower genital tract of female children, involving the labia minora, hymen, vestibule, urethra, Skene's glands, Bartholin's glands, the vagina, and the portio vaginalis of the cervix. Norris and Mikelberg recommend the use of the term Cervicovaginitis rather then Vulvovaginitis because the cervix is often the principal seat of the infection. The infection is of two main types: (1) the specific or gonococcal variety; (2) the non-specific or simple variety. Since for all practical purposes, except for the causative organism and the difference in degree of the severity of the symptoms, the two are alike, the gonococcal type alone will be considered.

Beckman of Marquette University states that "gonorrhea in girl children outranks in incidence a large number of the infectious diseases in children, running perhaps second to measles and outnumbering smallpox and scarlet fever." According to Brunet and Dickinson, specific vulvovaginitis affects one to five per cent of the young females in the poorer sections of large cities. When one regards the importance of vulvovaginitis in children as a disabling and distressing condition one is struck by the almost total ignorance on the part of the lay public concerning this disease; the astonishing lack of success in its treatment; and the prevalence of this disease in every community.

All authorities are agreed that the gonococcus is the most frequent causative agent of vulvovaginitis in children. Taussig says that for all practical purposes vulvovaginitis may be termed gonorrhea. Norris by the use of centrifugal vaginal washings for bacteriologic examination was able to demonstrate gonococci in ninety-seven percent of a series of cases but at the same time he places little faith in the microscopic diagnosis and depends more on the clinical evidence. On the other hand, Stein, Williams, Hurden, and other investigators, place the numbers as ranging from twenty-five to fifty percent in their series.

Infection may come from contact with linens, sponges, towels used by adults or children suffering from gonorrhea; from the toilet seat, particularly the type not having the U-shaped opening in front; from the use of the same clinical thermometer on several children in succession, the thermometer frequently being passed over the vulva in attempts to take rectal temperatures; from depraved sexual practices. The same organism causing adult gonorrhea causes vulvovaginitis in children. Yet the conditions of the two are so dissimilar in their effects that they should be regarded as separate disease entities. Primarily this is due to the anatomical and physiologic difference between the child and the adult woman. In children, the lining epithelium of the vagina is simple columnar in type. Only as the child develops into adult life does the surface epithelium of the vagina and vulva change into a squamous variety which is more cornified and resistant. In the child, also, the genitalia are comparatively unprotected. They are smooth, hairless, and averted. The labia are small and seldom in complete opposition. The absence of menstruation and the fact that the vaginal flora, particularly Doderlein's bacillus, does not make its appearance until puberty are other important factors in explaining why primary gonorrheal infection of the vulva and vagina is a disease affecting children almost exclusively.

The onset of the diseases as a rule is sudden. The child complains of a burning or itching on urination. There is usually noticed on the child's clothing a foul smelling discharge, yellowish-white or yellowish-green in color. The entire vaginal nucosa becomes intensly inflamed and is bathed in thick, creamy pus. From the vaginal introitus is seen to come the purulent secretion which covers the labia, vestibule, and hymen. The vulvar orifice shows evidences of the inflammatory process; redness, heat, and swelling being apparent. The discharge is thickest usually at the upper portions of the vulva and around the clitoris. Excoriation of the vulva may accompany a surrounding intertrigo.

---

*From Englewood Hospital, Richard O. Shea, M.D., Director

Fortunately, complications and sequelae are uncommon. The disease has little tendency to ascend above the vagina into the uterus and tubes. However, much damage may be done in the vagina as a result of the tendency to ulceration of the vaginal mucous membrane with consequent plastic adhesions. This is one of the commonest causes of acquired gynetresia. In about 10% of the cases, the urethra is infected, the cervix being still more often infected than the urethera. General peritonitis is occasionally encountered, but Norris believes it to be the outcome of a gonorrheal septicemia rather than caused by upward extension through uterus and tubes. Inguinal adenitis is one of the commonest complications but is not often suppurative. Arthritis is one of the more common complications, and in our series was present in two of the fifty-nine cases. Extension of the disease to rectum and anus has been reported. The possibility of permanent anatomical damage with the production of such conditions as pinhole os, gynetresia, uterine and adnexal malformations causing sterility in an otherwise healthy woman is considered by Fraser as one of the serious aspects of this disease. Most gynecologists, however, are of the opinion that the vulvovaginitis of children leaves no sequelae in adult life and does not interfere with the reproductive processes.

The course of vulvovaginitis is seldom less than eight weeks in duration, even under the most careful treatment. Many times the course is protracted over months before a cure is obtained. Apparent cure after two or three weeks of intensive treatment is frequently encountered. But relapses occur with discouraging frequency and smears may continue positive for much longer periods. Untreated, the disease lasts for a long time and may die out only with the advent of puberty.

During the past twenty years, numerous therapeutic measures and methods of treatment have been advocated to cure the disease, with many unsatisfactory and often disappointing results. These measures have varied from local applications of douches, ointments, instillations, to sitz baths, physiotherapy, vaccine therapy, the use of estrogenic substances and chemotherapy. Since the therapy used and the results obtained from that particular plan of treatment in our series of cases, which extends over the eighteen year period from 1922 to 1939, closely approximate the results shown in the literature, we shall mention only the treatment used on our fifty-nine cases. Certain basic procedures were standard in all lines of treatment and were used routinely; namely, rest in bed during the acute stage of the disease, hygienic measures to improve the patient's general physical condition, scrupulous care in maintaining cleanliness of the external genitalia, and isolation of the patient.

A summary of the cases of Vulvovaginitis treated in Englewood Hospital follows. From 1922 to 1939, a total of fifty-nine cases of vulvovaginitis in children were treated in this institution, which serves as the infectious disease hospital for Bridgeport, Conn , a city with a population of approximately 150,000. During this eighteen year period, all but two cases were discharged as cured and these two cases were transferred to other institutions as improved. The average age of the patient treated was six and one half years. There were four patients below one yeai of age. Twenty-five patients were between one and five years of age. Twenty-five patients ranged between six and ten years of age and the remaining five patients varied in age from eleven years to fifteen years. The youngest patient to receive treatment was two months of age. The average stay in the hospital for all cases during this eighteen year period was seventy six days. The minimum hospital stay for one patient was six days and the longest stay in the hospital for any one patient was three hundred and eighteen days.

From the type of specific therapy favored by the hospital during certain years, we were able to group the cases into six arbitrary periods. Naturally, a certain amount of overlapping between these periods occurred as treatment trends changed. The periods were as follows:

1. From 1922 to 1924 —

   Five cases were treated by boric acid douches. The average stay in the hospital for these patients was 213 days before being discharged.

2. From 1925 to 1928 —

   Fourteen cases were treated. Following a boric acid douche, potassium permanganate, gentian violet, or an acriflavin instillation was used. The average stay in the hospital of these cases was 97 days before being discharged as cured.

3. From 1929 to 1932 —

   Fourteen cases were treated by mercurochrome and ten percent argyrol instillations into the vagina. The average stay in the hospital of these cases, before being discharged as cured, was 75 days.

4. From 1933 to 1934 —

   Six cases were treated by gonorrheal vaccines with an average stay in the hospital of these patients of 107 days before being discharged as cured.

5. From 1935 to 1936 —

   Six cases were treated during this period by estrogenic substances and local instillations of mercurochrome. The average stay in the hospital for these patients was 45 days before being discharged as cured.

6. From 1937 to 1939 —

   Fourteen cases of vulvovaginitis were treated during this period. Estrogenic substances and sulfanilamide was the specific therapy used. The average stay in the hospital for these patients was 49 days before being discharged as cured. Although the total number of cases in these series are fairly large nevertheless the particular type of therapy used was too varied to allow definite conclusions. It would appear that estrogenic therapy combined with instillation gave the best results.

REFERENCES

1. A. Reith Fraser — Vulvovaginitis in children — Med. J. of South Africa — Sept. 1925.

2. Brunet and Dickinson — Gonorrhea in the female — Reprint No. 14 from Venereal Disease Information — U. S. Public Health Service.

3. Norris and Mikelberg — J.A.M.A., 76:164, 1922.

4. Beckman — Treatment in General Practice — 2nd edition, 604-606.

5. Stein, I. F. — J. S. G. & O. — 36:43 (Jan.) 1923.

6. Scott, J.P. — The Cyclopedia of Medicine — Vol. XII, 976-980.

7. Gellhorn — J.A.M.A. — 75:1647, 1920.

8. Crossen and Crossen — Diseases of Women — 8th edition — 448-454.

9. Lewis, R. M. — Am. J. Ob. & Gynec. — 26:593. (Oct.) 1933

10. Te Linde, R.W. — J.A.M.A. — 110:1633 (May) 1938.

MEDICAL CARE A SOCIAL PROBLEM

As a matter of fact, the accomplishments of medicine in the United States in the past fifty years have been extraordinary, and have not been exceeded in any other country in the world. The average expectancy of life has been lengthened by twelve years between 1900 and 1937. The death rate has fallen to 11.2, which compares favorably with any of the large nations of the world, and there is still a steady improvement. There are more doctors per population and more hospital beds per population than in any other country. Undoubtedly there is plenty of room for improvement. I venture to think, however, that the difficulty is a social difficulty, and arise much more from the inadequacy of the income of millions of families than it does from any faults in the medical profession or lack of medical facilities.

Hon. Robert A. Taft, Ohio.

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.
(SEE PAGE 2.)

What Is A Neurosurgical Emergency?*

W. J. GERMAN, M.D.,
New Haven, Conn.**

The necessity for emergency neurosurgical treatment may arise in certain forms of congenital, traumatic, infectious or neoplastic lesions of the brain or spinal cord. Figure 1 illustrates the more common examples of these conditions together with an index of their relative urgency.

Cranial meningocele, when leakage of spinal fluid is present or threatened, should be repaired as soon as possible to avoid the hazard of infection. This hazard is more frequently encountered in cases of *spinal meningocele* or myelomeningocele and the same indication for early closure is present.

Traumatic lesions involving the central nervous system or its coverings are the most frequent sources of neurosurgical emergency. *Compound fractures* require early irrigation, debridement and closure if possible within the first six hours after injury in order to prevent infection. Extensively contaminated cerebro cranial wounds with loose particles of bone are probably best handled by block debridement to insure complete removal of foreign bodies and devitalized tissue. The incidence of infection in these wounds rises rapidly after the first six to twelve hours.

Hematoma, either *extradural* or *subdural*, is frequently a source of extreme urgency because of rapidly mounting intracranial pressure. This is particularly true of the extradural type because the bleeding is usually arterial in this case. The occurrence of a lucid interval followed by progressive signs of increased intracranial pressure, unilateral dilatation of the pupil and unilateral paralyses are diagnostic signs strongly suggesting the presence of a hematoma. Extradural hematomas are best attacked through a subtemporal decompression and the source of hemorrhage, usually the middle meningeal artery, must be arrested. Subdural hematomas can frequently be evacuated through properly placed burr holes over the suspected site of the hematoma. It is well to remember that homolateral signs may be present in certain cases of subdural hematoma and in these cases *bilateral* burr holes may be necessary to disclose the lesion.

Traumatic injuries to the spine may necessitate emergency neurosurgical procedures, especially the diving injuries with *fracture dislocation* of the cervical spine. Ill advised manipulations of the head by ambulance attendents or bystanders may serve to increase the injury to the spinal cord. These patients can be safely transported by rolling onto a board or rigid stretcher with the neck in extension. The dislocation may be treated most satisfactorily by skeletal traction applied to the cranium. *Hematoma* of the spine producing progressive loss of spinal cord function is an indication for emergency laminectomy to relieve pressure upon the spinal cord. Loss of function following an injury together with the presence of a block on Quackenstedt test, usually associated with bloody spinal fluid, are the characteristic signs of this entity. Recovery is rarely if ever observed in patients having complete immediate loss of all spinal cord function.

Brain abscess usually arises as the result of extension of infection from the accessory sinuses to the brain. Signs and symptoms of increased intracranial pressure are usually present and immediate drainage of the abscess is indicated if these signs are advanced. *Epidural abscess* of the spine may be extremely fulminating in its course and is usually associated with *pain* and progressive loss of spinal cord function. A block is usually demonstrable on Quackenstedt test and the spinal cord pressure may be relieved by laminectomy at the appropriate site.

---

*Read before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.
**Department of Surgery, Yale University School of Medicine.

Cerebral tumor is an indication for emergency treatment *only* when the patient is first seen in the terminal stage. In this case, craniotomy with tumor removal may be a life-saving measure. *Cerebellar tumors* are a more frequent source of rapidly-mounting intracranial pressure, due to progressive hydrocephalus. This is particularly true in children where the early symptoms may be overlooked or misinterpreted. Vomiting, especially on arising in the morning, is the symptom which is most frequently misinterpreted. The emergency situation may often be relieved by tapping the ventricle, allowing a more deliberate approach to the tumor at a later date. *Lumbar puncture is dangerous. Spinal cord tumors*, though not an immediate hazard to life, may give cause for emergency treatment when rapidly-progressive signs of spinal cord pressure occur. If relief of pressure is delayed under these circumstances, functional loss may be permanent.

NEUROSURGICAL EMERGENCIES

	Congenital	Traumatic	Infectious	Neoplastic
Cranial	Meningocele±	Compound Fracture++	Brain Abscess++	Cerebral Tumor+
		Extradural+++ Hematoma Subdural++		Cerebellar Tumor++
Spinal	Meningocele+	Fracture Dislocation+ Hematoma++	Epidural Abscess++	Spinal Cord Tumor+

Figure 1.

* * *

1939 BIRTH RATE AND INFANT MORTALITY RATE

The United States birth rate dipped slightly last year after rising in 1937 and 1938, according to preliminary tabulations of the Census Bureau, Department of Commerce.

A total of 2,262,726 births occurred last year, resulting in a birth rate of 17.4 births per each 1,000 estimated population. In 1938, the birth rate was 17.6, based on 2, 286,962 births. The rate in 1937 was 17.0.

The preliminary 1939 rate is approximately 5 percent higher than the lowest birth rate recorded in the history of the birth registration area established by the Census Bureau in 1915. The low point was in 1933 when the rate was 16.5. Census officials cautioned that the slight increase reported in recent years cannot be taken as assurance that the gradual decline of the birth rate has been checked.

With a birth rate of 13.5 Connecticut was second only to New Jersey in 1939.

The lowest infant death rate in the nation's history was recorded in 1939, according to preliminary tabulations made public today by the Census Bureau, Department of Commerce.

The 1939 infant death rate of 48.0, deaths per one thousand live births is based on 108,532 deaths of infants under one year of age. In 1938 there were 116,702 deaths which resulted in a rate of 51.0. The 1937 rate was 54.4 based on a total of 119,931 deaths. The record-breaking mark of 1939 represents the culmination of two decades of general decrease in infant mortality.

Here again Connecticut ranked second lowest with an infant mortality rate of 36.1, being surpassed only by Minnesota.

* * *

SOUTH CAROLINA APPEALS FOR PHYSICIANS

We learn from the Journal of the South Carolina Medical Association that there are many small communities in that State interested in finding good doctors who will locate in their midst. For the past two years the requests have been extremely urgent and only recently it was noted that the South Carolina Medical Journal carried an advertisement announcing a field open to a young physician "who had had and is inclined toward surgical experience." This opportunity may appeal to one who dislikes the rugged New England winters. South Carolina is making rapid strides in scientific medicine and is no longer the backward State it was during the days of the World War.

Modern Treatment of Pneumonia*

THEODORE S. EVANS, M.D.,
New Haven, Conn.

The conquest of pneumonia by the biologist and the experimental chemist was protracted and filled with pitfalls. Digitalis was formerly used a panacea. This was followed by the use of concentrated glucose intravenously still of value along with blood transfusions as an adjunct to specific therapy. Physio-therapy (Diathermy) was employed by many but was expensive and gave little evidence of altering the course of the disease. Doctor F. G. Blake and his associates at Yale Medical School revived the use if pneumo-thorax in patients who did not fall into the serum specific groups. This proved to be but a method of symptomatic therapy for the relief of pleural pain and did not cure the infection or reduce the mortality.

As early as 1922 serum for group I pneumonia was used, in large quantities at first because of its low potency. At the Grace Hospital in 1938 the first concerted effort was made to use serum in all possible cases and to use sulphanilamide where there was a clear cut indication. In 1939 pyridine sulphanilamide, furnished by Merck & Co., was used in nearly all cases of pneumonia at Grace Hospital in order to test its efficiency. Serum was still used in certain cases as was plain sulphanilamide.

Results of Treatment

The results of our experience afford no general conclusions as the number of cases is small but in general our results are similar to those of others who have worked under similar conditions. From 1933 to 1937, inclusive, before the use of serum or sulphanilamide the death rate was approximately 33%. In 1938 with serum the death rate dropped to 11%. In 1939 with serum, sulphanilamide and pyridine sulphanilamide death rate fell to 5%. The reductions in mortality for the past two years are apparently due to these agents in large measure.

In 1938 there were no deaths among 11 cases of lobar pneumonia treated with serum and but one death among 20 cases treated with sulphanilamide. During the first 10 months of 1939 the results of treatment of lobar pneumonia were as follows: serum treated cases 9, no deaths; sulphanilamide treated cases 4, one death; pyridine sulphanilamide treated cases 49, three deaths; serum or serum in conjunction with other therapy 20, no deaths. The latter group for the most part was a selected one in that it comprised early cases and received serum early in the disease. Cases treated with sulphanilamide alone or in combination with other therapeutic measures numbered 24 with one death. This group comprised selected cases in that the drug was given only when there seemed to be clear cut indication. In the pyridine sulphanilamide group it was necessary to formulate our own dosage. All of the three fatal cases were extremely ill and received the drug as a last resort.

In those cases where streptococci are present in the sputum we have found pyridine preferable to plain sulphanilamide. In the staphyloccus infections there seems to be little evidence that either of these drugs is of great benefit.

Dosage

With serum 100,000 units are given, followed later by more serum if the individual case seems to demand it, though many will have a crisis after the first 100,000 units.

Our doses of pyridine have been smaller than those recommended by others but our results compare favorably and our sequellae have been less frequent and less severe. We give 2 grains at once, then 1 grain every 4 hours day and night until temperature has been normal for 24 hours, then ½ grain every 4 hours for 6 doses. Children receive correspondingly smaller doses. Only three cases required hypodermoclyses because of vomiting. For this method 2 grains of the drug are dissolved in 1000 c.c. of 5% glucose or 1500 c.c. of normal saline at optimal temperatures. It may also be given intravenously in the same solution.

---

*Abstract of paper read before Greenwich Medical Society, Greenwich, Conn., Dec. 19, 1939.

Blood Concentration

This is a great variable since cases on the same dosage for the same time have very different concentrations. We fell that the optimum is an individual matter and probably should be judged as much by the clinical picture as by the blood figures. Somewhere between 5 and 10 mg.% seems to be the average figure at which the drug is clinically active. In those cases who respond quickly and who have only small amounts there is rarely much danger. It is in the occassional case where therapy is long continued that concentration figures are invaluable. Here we run into the danger of secondary fever and other sequellae. It is the tendency to regard fever after an interim of afebrile days as a result of the disease process; but we must not forget that the drug may itself cause fever. In these cases the drug should be continued or begun again only after blood concentration has been studied. Both the free and total sulphapyridine in the blood should be known in these cases, as acetylation may take place unpredictably and procedure with the drug might be attended with grave risk or even fatal results.

Choice of Therapy

Serum when used should be given early in the disease, within the first three days from the onset. The case must be one for which a type specific serum is available at once. Rabbit serum seems preferable to horse serum. Pyridine sulphanilamide is the choice if the disease is advanced or if the sputum contains a pneumococcus for which a specific serum is not available. It may be used wisely if there is delay in typing the sputum of if the patient cannot afford serum. Some writers recommend conbined serum and pyridine therapy, either early in group III pneumonias who appear very ill or in all patients coming in to the hospital late in the disease and appearing very ill.

Pyridine sulphanilamide should never replace serum as the latter under proper conditions will terminate the disease promptly and permanently. Pyridine apparently holds the disease in check until the normal body defences can step in and terminate the disease. Serum is not attended with the sequellae reported from pyridine and sulphanilamide, the worst effect being a violent serum reaction which is of short duration and rarely dangerous.

Advantages and Disadvantages of Pyridine Sulphanilamide

Pyridine is always available, easily administered and inexpensive. Its disadvantages are headache, dizziness, cyanosis (less marked than with sulphanilamide), nausea and vomiting in some instances. Fever definitely ascribed to the drug was noted in but two instances. Hemolytic anemia was noted in but two instances where it assumed any clinical significance and these yielded promptly to discontinuance of the drug. Icterus is usually present. During periods of active therapy a daily red blood count is advisable. Leukopenia was observed but once and may be forestalled by daily white blood counts. Gross hematuria was observed but once and that patient had microscopic blood in the urine on entrance to the hospital. Microscopic hematuria was observed in but five cases, no more than the rule in untreated cases.

Treatment with pyridine should be stopped if any of the following appear: abdominal pain, hematuria, icterus, anemia, leukopenia, fever, dermatitis or hepatitis.

Home treatment with pyridine sulphanilamide must be guarded against as unsafe. Failure to hospitalize patients will result in failure to use serum and this in turn may result in less improvement of serum.

* * *

THE SHOEMAKER'S CHILDREN

A seven-year study of the nurses in the New York Hospital disclosed that 47 cases of tuberculosis have been found among 2,841 graduate nurses and 3 cases among student nurses. Most of the graduate nurses found to be infected were recent graduates and the report states that for some it was not only their first job but also their first x-ray. Elsie Davis, R.N., and Harriet Frost, R.N., Amer. Jour. of Nursing, Apr., 1940.

The Connecticut State Medical Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief,*	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Stamford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

WORK BESIDE OF WORK

There are some fortunate men in medicine who find their avocation in artistic creation. It must be a very satisfactory escape from the day's tasks.

Physicians from all over the country exhibited their work during the meeting of the American Medical Association. Connecticut was well represented. The panel by J. Louis Jack of New Haven created a great deal of interest, it was an allegorical figure of a physician in operating accoutrement. The "Rain Barrel," a water color by William W. Wright of West Hartford is the sort of picture that most ànyone could live with. His oils, "Polish New England" and "Between the Acts" were neither of them quite as pleasant. "Summer Rain" and "Canal, Chartres," two oils by John C. White of New Britain, impressed this old exhibit goer as two of the nicest things in the show. "Summer Rain" was badly hung and crowded so that it did not appear to the advantage that it deserved; "Canal Chartres" was so softly done that it was a plaesure to stand and look at it, the style is nicely reminiscent of George Innes.

There were ups and downs in the exhibit, some of it was good and some was not, but on the whole it was interesting and could have been improved only if it had included some of Herbert Thoms' vigorous etchings of the New England scene and Arthur Alling's water colors.

Idler

* * * *

NATIONAL HEALTH LEGISLATION

On May 30 the United States Senate passed the Wagner-George bill (S.3230) now designated as "a bill to provide for the general welfare through the construction of needed hospitals and grants to States and political subdivisions thereof for the construction, improvement, and enlargement of hospitals, and for other purposes." The original Wagner bill (S.1620) died a painless death, unlamented, at least in Connecticut. This death may have been due to pecuniary inanition as suggested by our own Committee on National Legislation but an aroused medical and public opinion should receive some credit. Since the rise and fall of the Wagner bill the procession of proposed national health measures deserves our careful scrutiny. With the Editor of the New England Journal of Medicine we ask the question, "Why are such bills introduced?" The answer would not seem to be quite as simple as our neighbor suggests, for, granted the medical profession may have been at fault in not using its united influence to secure better laws, more efficient local governments and better administration of medical relief, yet certainly it cannot assume responsibility for the social unrest, evolution, yes, even revolution pervading the world today. Never has a government of these United States been as socially minded as the one now in power.

President Roosevelt recently suggested as a preliminary measure to remedy the lack of adequate medical care in this country the expenditure of $10,000,000 for the construction of hospitals in communities where they are needed. Hence the Wagner-George bill which may be considered an introductory experimental effort of the federal government on a modest scale to carry through piecemeal the program proposed in the original Wagner act. A similar measure was introduced in the House by Representative Lea of California (HR.8240). The Senate Committee on Education and Labor reported the Wagner-George hospital construction bill (S.3230) to the Senate Apıil 30, recommending that all after the enacting clause of the bill be stricken and suggesting substitute provisions drawn, partly from the original bill, partly from recommendations made to the committee at the hearing recently conducted on that bill, and partly from Senator Taft's hospital construction plan. Representatives of organized medicine by their suggestions had much to do with the changes made in the original bill.

As it stands the Act proposes a six year program for providing needed hospital facilities under four headings:

1. The appropriation to the United States Public Health Service of $10,000,000 annually for six years beginning with the fiscal year ending June 30, 1941, this money to be used to assist states, counties and districts through construction, improvement and enlargement of needed hospitals, especially in rural communities and economically depressed areas.

2. Annual appropriations to the same department of the government of $500,000 foı six years for the administration of these hospitals.

3. The annual appropriation each year for five years ending with June 30, 1947, such sums as may be necessary for hospital maintenance grants under the act.

4. The appropriation of such sums as may be required by the Public Health Service, after the initial six year period, for necessary expenses in administering such provisions of the act as may then be in operation.

Two construction plans are contemplated under the act, Plan I requiring the approval of the National Advisory Council, and after the completion of the hospital the leasing by the Surgeon General to the applicant of the hospital, equipment and land. This lease may be forfeited if the Surgeon General finds the lessee has failed to comply with the regulations or with any provision in the lease but it does not provide for operation of the hospital after the lease is cancelled. Plan II requires the approval of the Surgeon General alone and provides for grants to be made after the first year to states, counties, health or hospital districts to aid in defraying the cost of constructing needed hospital facilities. The House of Delegates of the American Medical Association at its recent session held in New York City recommended that hospitals be built only in communities where actual need can be shown, and where local government units can demonstrate their ability and willingness to maintain the institutions when built.

The National Hospital Advisory Council here provided for will consist of the Surgeon General of the Public Health Service as chairman and eight members appointed by him with the approval of the Federal Security Administrator selected from leading medical and hospital authorities. The Surgeon General is required to consult with other Federal health and welfare activities and to cooperate with them in the training of personnel, in maintaining proper standards of medical service in hospitals constructed, and in studying further needs for hospitalization and hospital operation. Two amendments were made to the bill as reported in the Senate, one including the osteopaths among the leading authorities from whom the Council shall be selected, the other assuring that the facilities to be constructed under the bill will be made available without discrimination on account of race, creed or color. Both were unanimously adopted. To the former amendment the House of Delegates of the American Medical Association has voiced its objection.

Two other proposed measures, the Mead bill and the Lodge bill, have apparently been buried in committees. The former entitled "The Health Security Act of 1940" authorized appropriations for loans to public bodies and non-profit organizations including hospitals, not more than one-third of the entire sum to be devoted to the latter. Senator Mead believed this bill would supplement the Wagner hospital bill. The Lodge bill was introduced as an amendment to the Social Security Act and appeared in two parts. The first part proposed cash benefits from the old age insurance fund, created under the Social Security Act, on behalf of certain unemployed individuals who receive medical, dental or hospital care, or whose wife, child under the age of 16, or wholly dependent parent receives such care. The second part of the Lodge bill would add a new title to the Social Security Act to be captioned Grants to States for Medical Services and Facilities. This makes available certain medical services and facilities which at present because of their cost are beyond reach of many. It puts the federal government into the field of curative medicine by attempting to solve but one phase of a large problem.

Some form of national health legislation is certain to be enacted and the Wagner-George bill, already passed the Senate, is therefore the most likely. We can no longer stand aloof and criticize for by so doing we invite the politician and the lay social worker to occupy seats intended for us. Doctor Fishbein, Editor of the Journal of the American Medical Association, believes that the Wagner-George bill should be modified so that the definition of the term "hospital" covers institutions primarily for the care of the sick rather than health, diagnostic and treatment centers. Also he believes it should be amended to eliminate the meaningless reference to "outstanding" osteopathic authorities, to give the Advisory Council a positive voice in the construction program not only for the first year but also during the last five of the six years that the act will be in operation, and to provide for the selection of the members of this Council by the Chief Executive. To the Committee on Interstate and Foreign Commerce of the House of Representatives we now look for these amendments.

The House of Delegates of the American Medical Association is to be congratulated on the stand it took at its recent session when it urged each State medical society to create a special committee to act in an advisory capacity to State Health Departments on any hospital construction project contemplated under the pending legislation. Our own Society is awake and will have its committee in readiness to assist Doctor Osborn should any hospital construction be contemplated in Connecticut.

* * * *

DOCTOR HORNING RESIGNS

It is with a deep sense of regret and a feeling of personal loss that the Editor records the resignation of Benjamin G. Horning as Health Officer of the City of Hartford. Doctor Horning's four years of service to that city have been outstanding in accomplishment and progress. To repeat Mayor Spellacy's comment, "Doctor Horning's motto has been 'service.' " During his four years of service Doctor Horning has seen the local Health Department thoroughly reorganized and its services developed and expanded. A city wide program of tuberculosis control has been inaugurated with the establishment of an adequately equipped clinic, a city wide health education program has been developed, bureaus of maternal and child hygiene have been organized, and a dental clinic for pre-school children has been established.

Our sincerest wishes for even greater success in his chosen field go with Doctor Horning as he assumes his new duties as associate field director of the American Public Health Association for the United States and Canada.

* * * *

GOOD DOCTORS WORK LIKE DETECTIVES

The competent doctor works like a detective, and his extensive cross examination of the patient is one of his most important means of finding clues to proper diagnosis, Peter J. Steincrohn, M.D., Hartford, Conn., maintains in the June issue of *Hygeia, The Health Magazine.*

"The mind of the good diagnostician is soon cluttered with clues of all sizes, shapes and colors which he must literally drag out of you with questions," he says. "Then he must sort these out and through a process of exclusion (gained by long clinical experience) be able to throw many out the window of his consciousness. To make a diagnosis and be fairly certain about it, the complete cross examination of the patient is absolutely essential.

"Sometimes physical examination yields absolutely nothing. The positive signs of disease may not rear their heads until valuable months have slipped by. But symptoms often come early to warn against illness."

The patient, therefore, should be glad if he has a doctor who spends a great deal of time in asking questions. The physician who asks few or none should be shunned.

* * * *

WHAT OTHERS THINK ABOUT OUR CANCER HANDBOOK

From Olin West, Secretary, American Medical Association: —

Dear Dr. Barker:

Within the last two or three days I have found opportunity at various times to examine the handbook prepared by the tumor committee of the Connecticut State Medical Society, a copy of which you were good enough to send me a month or so ago.

I have found the handbook intensely interesting and think that it is splendid. I am enclosing a copy of a letter that I have written Doctor Larkin.

With all good wishes, I am

Sincerely yours,
Olin West

Dear Doctor Larkin:

Our mutual friend Creighton Barker was good enough to send me some weeks ago a copy of the handbook on cancer prepared by the Tumor Committee of the Connecticut State Medical Society of which you are chairman.

Within the last two or three days I have taken advantage of such opportunities as have offered to examine the handbook. I have found it exceedingly interesting and most helpfully informative. I feel that the Connecticut State Medical Society and its tumor committee are to be congratulated on the splendid work that the committee has done in producing the handbook. The members of the committee have evidently devoted a large amount of time and careful effort to its production and have, in my opinion, rendered distinguished service to the members of the medical profession in Connecticut and to physicians elsewhere who may be privileged to have the handbook available for reference and guidance.

With assurances of my sincere respect and esteem, I am

Very truly yours,
Olin West

From Tom Hendricks, Secretary, Indiana State Medical Association: —

Dear Dr. Barker: —

Thanks so much for your two letters, both of which I greatly enjoyed and appreciated.

The cancer handbooks have arrived and we are sending a copy to each member of our Committee on Cancer Control. I know that they will be most pleased to receive this booklet. We asked Doctor Chester Stayton, co-chairman of the committee, to review your book for the April issue of THE JOURNAL of the Indiana State Medical Association and we are enclosing a copy of his review.

Sincerely yours,
Tom Hendricks

CANCER

A Handbook for Physicians

This cancer pamphlet was prepared by doctors who are especially trained and interested in the subject of cancer. They are members of the Connecticut State Medical Society Tumor Committee and the Division of Cancer Research of the State Department of Health.

The book covers the entire field of the cancer problem, including the organization of the cancer work in the State of Connecticut and a short, comprehensive discussion of the three effective methods of treating cancer, namely: surgery, roentgen ray and radium therapy. A chapter is devoted to the value, limitations and methods of biopsy.

There are separate chapters devoted to neoplasms of the skin, the eye, lip and buccal cavity, respiratory tract, thyroid gland, breast, lung, pleura and mediastinum, gastrointestinal tract, genitourinary tract, bone tumors, female generative organs, blood dyscrasia and lymphoblastomata. There is also a chapter devoted to the palliative treatment of incurable malignancies.

The general practitioner in the State of Connecticut is extremely fortunate in having such a comprehensive reference book on the subject of cancer. Each chapter deals with the incidence, etiology, signs and symptoms, diagnosis treatment and prognosis.

The Editorial Committee of the Tumor Committee of the Connecticut State Medical Society is to be congratulated upon the very practical manner in which this subject is presented.

Indiana State Med. Jour.

* * * *

THE NEXT CLINICAL CONGRESS

The formal talks at the 1940 Clinical Congress will be shortened from 45 to 30 minutes.

The entire program of the 1940 Clinical Congress will be carried out within the Sterling Law Buildings.

The luncheons will be resumed at the 1940 Clinical Congress. At each luncheon there will be a talk by some prominent speaker with opportunities for questions and answers.

The afternoon session of the 1940 Clinical Congress will be very practical and will include dry clinics as well as demonstrations of actual diagnostic and therapeutic procedures.

* * * *

THIS IS REAL CIRCULATION

Oliver H. Bartine, Superintendent of the Bridgeport Hospital, places copies of the JOURNAL each month in the following: — President's office downtown, Superintendent's office, office of the Assistant Superintendents, the Night Superintendent, the Nursing School, the Nursing School Library, the Medical and Circulating Library, the Dietary Department, the Cashier's Office, the Laboratory, the X-ray Department and the Social Service Department. By this real circulation Mr. Bartine is giving everyone in his hospital a chance to read the JOURNAL and thus become better acquainted with the work of the Connecticut State Medical Society and the Connecticut Hospital Association.

Every hospital in the State can do the same. If you need more copies, write the JOURNAL office.

* * * *

WILLIAM W. BACKUS HOSPITAL, NORWICH

Miss Nell A. Hostetler assumed the duties of the Superintendent of the School of Nursing at the Backus Hospital May 1, 1940.

Miss Grace Anslow, former Superintendent of the School of Nursing resigned and has opened a convalescent home in Norwichtown.

The Backus Hospital has discontinued its dairy and disposed of the herd of cattle, and other animals. This was done mainly for the purpose of sanitation as it was felt it is impossible to have animals so close to an institution without forming a great source of flies.

The State of Connecticut Highway Department has altered markedly the entire front of the hospital property by way of grading the bank along the main highway and seeding this.

* * * *

A NEED BUT NO DEMAND

In view of all the interest developed in prepaid medical service plans, the report from the Mutual Health Service of the Medical Society of the District of Columbia is enlightening. The Service was organized following the Society's approval of its establishment on April 5, 1939. It is now suspending operation and on the basis of its experience its Board is convinced that even though there is a need there is no demand among a majority of low income workers in the District of Columbia for a prepayment medical service program. The Medical Society has demonstrated its desire to discover, if possible, better methods of making medical care more available to the low income group. Apparently there is a considerable amount of educational work which must be done before there will be any enthusiasm for such a program and the Medical Society does not believe this is its responsibility. The principal objections raised were that the income levels are too low and that the subscriber rates are too high.

* * * *

NEW ENGLAND GUILD, INTERNATIONAL COLLEGE OF SURGEONS

The first spring meeting of the New England Guild, International College of Surgeons, was held March 27 at the Hospital of St. Raphael, New Haven, under the direction of the New England Activities Committee. An operative clinic was held during the forenoon. Preceding a dry clinic in the afternoon, Doctor Joseph I. Linde, Health Officer of New Haven, addressed the gathering. Short papers were presented on surgical subjects by Doctors J. A. Gettings, Dennis O'Connor, Andrew McQueeney, Edward Kirschbaum, A. J. Mendillo, William J. German and Robert Nesbit.

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

AMENDMENT TO THE BY-LAWS

Adopted by the House of Delegates May 21, 1940. Chapter II, Section 1, Paragraph 2, amended to read:

> The annual tax shall be collected from all such members except the secretaries of the County Medical Associations. Members who have been in good standing in the Society for forty consecutive years or who have attained the age of sixty-eight and shall have been members of the Society for fifteen years immediately preceding, shall upon written request addressed to the Treasurer of the Society, be exempted from the further payment of dues and will continue as active members of the Society enjoying all rights and privileges. The tax of any member may be remitted by majority vote of the House of Delegates upon recommendation of any County Medical Association.

THE COUNCIL ORGANIZES

The Council for 1940-1941 held its organization meeting according to the By-Laws on Thursday, May 23, the last day of the annual session. Doctor James R. Miller of Hartford, now a member of the Council ex-officio as a delegate to the American Medical Association, was elected Chairman. Other members of the Council are:

The President, Arthur B. Landry, Hartford
The President-Elect, James D. Gold, Bridgeport
The Executive Secretary
The Treasurer, Hugh B. Campbell, Norwich
The Editor of the Journal, Stanley B. Weld, Hartford
Delegate to the American Medical Association, George Blumer, New Haven
Fairfield County, Samuel F. Mullins
Hartford County, Edward J. Whalen
Litchfield County, Charles H. Turkington
Middlesex County, Alfred N. Sweet
New Haven County, Thomas P. Murdock
New London County, George H. Gildersleeve
Tolland County, Charles T. LaMoure
Windham County, Robert C. Paine

COMMITTEE TO REVISE THE BY-LAWS

The House of Delegates authorized the appointment of a committee from the Society to study, revise and recodify the By-Laws of the Society and to report to the House of Delegates at its annual meeting in 1941. The Council has appointed the committee as follows:

D. Chester Brown, Danbury, *Chairman*
Charles G. Barnum, Groton
Cole B. Gibson, Meriden
William M. Shepard, Putnam
Thatcher W. Worthen, Hartford

COMMITTEE TO STUDY STATUTES REGULATING THE CONDUCT OF THE OFFICES OF COUNTY CORONERS

The House of Delegates at its annual meeting on May 21 authorized the appointment of a committee from the Society to study existing statutes regulating the conduct of the offices of the county coroners and, if advisable, to suggest revision of those statutes. The Council has appointed the committee as follows:

Chairman, Stanhope Bayne-Jones, New Haven. Professor of Bacteriology and former dean, Yale School of Medicine.

Henry N. Costello, Hartford. Former medical examiner, City of Hartford.

Louis P. Hastings, Hartford. Pathologist, St. Francis Hospital.

Edward H. Kirschbaum, Waterbury. Medical examiner, City of Waterbury.

Albert J. Robinson, Hartford. Medical Director, Connecticut General Life Insurance Company.

TESTIMONIAL DINNER FOR DOCTOR GOLD

Doctor James Douglas Gold of Bridgeport who has been a member of the Council since 1926 and its Chairman since 1933, was given a testimonial dinner by the present and former members of the Council on the occasion of his retirement as Chairman at the Hartford Club on May 21, 1940. Doctor Joseph I. Linde, President of the Society, presided and there were present Doctors Arthur B. Landry, Thomas P. Murdock, Walter R. Steiner, Robert C. Paine, Charles T. LaMoure, Hugh B. Campbell, Daniel C. Patterson, H. Gildersleeve Jarvis, Stanley B. Weld, Roy L. Leak, D. Chester Brown, James R. Miller, George H. Gildersleeve, Charles G. Barnum and Creighton Barker. Doctor Gold was presented with an engraved pen and pencil set as a token of the esteem of his colleagues. The address of presentation was made by Doctor Murdock. Doctor Gold continues as a member of the Council ex-officio as President-Elect of the Society.

COMMITTEE ON PREPAID MEDICAL SERVICE

The Committee on Prepaid Medical Service met in a lengthy conference with insurance executives at the office of John C. Blackall, Commissioner of Insurance for the State of Connecticut, on May 29. A conference with physicians representing all parts of the State, designated by the Presidents of the County Associations, was held on June 19.

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

The Conference Committees of the Connecticut Pharmaceutical Association and the Connecticut State Medical Society met in joint session at the Hotel Bond on June 4. Every active member of each committee was present. Problems affecting both pharmacists and physicians throughout the State were discussed at length and a program contemplating the solution of as many of these problems as possible is now under consideration. The joint committee will hold its next meeting early in August in New Haven. Doctor Stanley B. Weld was elected chairman of the joint committee and John J. Dugan the secretary.

SESQUICENTENNIAL CELEBRATION

The Connecticut State Medical Society held its first meeting in Middletown on October 9, 1792. The 150th anniversary of that important event will be appropriately celebrated in Middletown by the Society during the year 1942. Preliminary plans for that celebration are beginning to take form.

The House of Delegates at its annual meeting on May 21 authorized the President "to appoint and designate the Chairman of a committee from the Society that will be known as the 150th Anniversary Committee. This Committee shall, in cooperation with the local Committee on Arrangements appointed by the Middlesex County Medical Association, be charged with fixing the date for the arrangement and direction of the celebration of the 150th anniversary of the founding of The Connecticut State Medical Society . . . . ."

The President of the Society announces the appointment of the 150th Anniversary Committee:

George Blumer, *Chairman*, New Haven
C. Brewster Brainard, Hartford
D. Chester Brown, Danbury
Francis H. Burke, Rockville
Ernest J. Caulfield, Hartford
Cecil R. Garcin, Danielson
Cole B. Gibson, Meriden
James D. Gold, Bridgeport
Crawford Griswold, Bridgeport
Samuel C. Harvey, New Haven
Arthur B. Jackson, Washington
Charles S. Knapp, Greenwich
Alfred Labensky, New London
Michael J. Lawlor, Waterbury
Roy L. Leak, Middletown
Robert J. Lynch, Bridgeport
Michael J. Morrissey, Hartford
Louis H. Nahum, New Haven
Maurice T. Root, Hartford
George M. Smith, Pine Orchard
Peter J. Steincrohm, Hartford
Walter R. Steiner, Hartford
Daniel L. Sullivan, New London
Herbert Thoms, New Haven
Stanley B. Weld, Hartford
Benedict N. Whipple, Bristol

The Committee on Arrangements from the Middlesex County Association consists of:

Roy L. Leak, *Chairman*, Middletown
Carl C. Chase, Middletown
Harry S. Frank, Middletown
Charles Russman, Middletown
Harold E. Speight, Middletown

From the A. M. A. Convention

CREIGHTON BARKER, M.D.

MEMBERS OF THE CONNECTICUT STATE MEDICAL SOCIETY RECEIVE AMERICAN MEDICAL ASSOCIATION SCIENTIFIC AWARD

The exhibit showing the clinical and geographical features of a rural epidemic of poliomyelitis presented at the New York meeting of the American Medical Association by John R. Paul and James D. Trask of New Haven was awarded the silver medal in Group I.

Studies of the transmission of poliomyelitis virus in sewage have been made in a number of localities and epidemics by Doctor Paul and Doctor Trask and the results of their investigations are quite convincing.

FRANK H. LAHEY, PRESIDENT-ELECT AMERICAN MEDICAL ASSOCIATION

It has been many years since a physician from New England has been the President of the American Medical Association, and the profession in this district will receive with pride and approval the election of Frank H. Lahey of Boston to be the President-Elect of the Association.

Doctor Lahey was born in Haverhill, Massachusetts on June 1, 1880, and was graduated from the Harvard Medical School in 1904. He has twice served as an instructor in surgery at Harvard and as the professor of surgery at Tufts College Medical School. He is Surgeon-in-Chief at the New England Deaconness Hospital and the Northeast Baptist Hospital and Director of the Lahey Clinic, Boston. During the World War, Doctor Lahey served as Director of Surgery in Evacuation Hospital 30 of the American Expeditionary Force. He is a member of the Board of Governors of the American College of Surgeons, a member of the American Association for the Study of Goiter of which he was President in 1906, a member of the International Society of Surgeons and the American Surgical Association. In 1931 he served as President of the New England Surgical Society. For several years Doctor Lahey has served as member of the Council on Medical Education and Hospitals of the American Medical Association from which he resigned at the time of his election to be President-Elect.

THE MEDICAL MILITARY SURVEY

At the request of the Surgeon General of the United States Army a resolution was presented to the House of Delegates of the American Medical Association at the New York meeting, seeking cooperation between the Association and the government for national defense. The resolution which was unanimously adopted included a tentative plan for the procurement of personnel in the Medical Corps of the United States Army.

A committee consisting of ten members of the House of Delegates and the officers of the American Medical Association, ex officio, was appointed to carry out this important project. Doctor Stanley H. Osborn, Health Commissioner of the State of Connecticut and Delegate to the American Medical Association from the Section on Public Health, was appointed a member of this Committee.

The plan for recruiting medical personnel for the army is designed to distribute the withdrawal of medical talent evenly through-out the country and prevent the stripping of certain communities of necessary doctors.

Maj. Gen. James C. Magee, Surgeon General of the United States Army, stated that the plan had been officially prepared on behalf of the medical corps and was a program not of conscription, but of voluntary service.

The program is divided into ten parts and it contemplates that the American Medical Association through the State Societies and component county associations, will conduct a survey of the medical profession in the nation. In this survey a canvass will be made for volunteers to determine who would be available for military service and who, on account of age, physical disabilities or commitments in civil capacities, should remain at home.

Those selected for military service will be listed according to their professional qualifications for special medical and surgical duties and must be qualified by the various specialist examining boards. The state societies will maintain a roster of their members stating qualifications, civil, marital and economic status, age and physical condition. The Committee from the American Medical Association will "maintain contact with all governmental agencies concerned with the prevention of disease and the care of the sick in both civil and military aspects so as to make available at the earliest possible moment every facility that the American Medical Association can offer for the health and safety of the American people and the maintenance of the American democracy."

The Connecticut State Medical Society has officially declared its willingness to cooperate in this program and will proceed at once upon the receipt of directions from the American Medical Association and the Surgeon General.

The national committee to direct the medical preparedness for the nation consists of Irvin Abell, Louisville; Stanley H. Osborn, Hartford; Walter G. Phippen, Boston; Harvey B. Stone, Baltimore; James E. Paulin, Atlanta; Fred W. Rankin, Lexington, Ky.; Roy W. Fouts, Omaha; Sam E. Thompson, Kerrville, Tex.; Charles A. Dukes, Oakland; John H. O'Shea, Seattle. Serving as ex officio members of the committee are: Nathan B. Van Etten, New York, president; Olin West, Chicago, secretary; Arthur W. Booth, Elmira, N.Y., chairman of trustees; Austin A. Hayden, Chicago, secretary of Board of Trustees, and Morris Fishbein, Chicago, Editor of Journal of American Medical Association.

The Doctor's Office

Dr. Simon B. Kleiner announces the removal of his office to 315 Whitney Avenue, New Haven. Practice is strictly limited to diseases of the rectum and sigmoid.

LABELING OF VITAMIN-CONTAINING ALCOHOLIC BEVERAGES

"Under regulations relating to the labeling of alcoholic beverages heretofore promugulated by the Federal Alcoholic Administration Division, United States Treasury Department, any irrelevant scientific or technical matter that tends to create a misleading impression or any representation of curative or therapeutic (treatment) effect which likewise tends to create such an impression is prohibited on labels," *The Journal of the American Medical Association* for April 27 says.

"On April 4 the administration issued an interpretative ruling declaring that henceforth these regulations will be violated if the labeling of any distilled spirit, wine or malt beverage capable of and made for beverage use refers to vitamin content, whether such reference specifically alludes to curative or therapeutic effects to be derived from the use of the product or merely states the fact that the product contains one or more vitamins. Because of the widespread sale and the use of medicinal and dietary remedies containing vitamins, the administration believes that references to vitamins on the labels of alcoholic beverages will lead a substantial number of consumers to believe that the drinking of such beverages will be of curative or therapeutic benefit owing to their vitamin content when the facts in all such cases that have thus far come to the administration's attention indicate that such expectation will not be fulfilled.

"Bona fide preparations for tonic and special dietary uses, sold as such and not as beverages, which are composed of a base of distilled spirits, wine or malt beverages to which vitamins and possibly tonic ingredients have been added, are not subject to the administration's labeling requirements if they are sold under labels which clearly indicate that they are intended for dietary or tonic rather than beverage use and if their composition conforms to all requirements of the Federal Food, Drug and Cosmetic Act of 1938 with respect to products so labeled."

Connecticut Hospital Association

MEETING OF THE STATE HOSPITAL ASSOCIATION.

The regular semi-annual spring meeting of the Connecticut State Hospital Association was held in conjunction with the meeting of the State Medical Society at the Hotel Bond on May 22, 1940.

The Board of Trustees held a meeting in the morning, at which a number of important matters were considered and referred to the Assembly for action. At this meeting the treasurer reported that the National Association had called four bonds in the amount of $400.00, and it was voted that these bonds be turned in to the National Association and the funds be placed in the savings account until the November meeting of the Assembly.

At the meeting of the Assembly in the afternoon, the following resolution on the death of Miss Mary Ellen McIntyre was adopted:

MARY ELLEN McINTYRE

"*Whereas*: Miss Mary Ellen McIntyre, Superintendent of the Meriden Hospital, Meriden, Connecticut, for a period of twelve years from 1927 to 1940, died on March 4, 1940, following a long illness; and

Whereas: Miss McIntyre was an outstanding representative of the nursing profession having directed the Schools of Nursing at the United Hospital, Port Chester, New York, and St. Luke's Hospital, Cleveland, Ohio, and was also affiliated with the work of the National League of Nursing Education; and

Whereas: In the field of hospital administration her service to the public as administrator of the Hillcrest Hospital, Pittsfield, Massachusetts, United Hospital, Port Chester, New York, New York Infirmary for Women and Children, New York City, and the Meriden Hospital, Meriden, Connecticut, won her the respect of all with whom she came in contact; and

Whereas: Mary Ellen McIntyre's memberships in the American College of Hospital Administrators, the International Hospital Association, American Hospital Association, New England Hospital Association, Connecticut Hospital Association, and Westchester County Hospital Association evidenced her keen interest in the advancement of the profession of hospital administration; and

Whereas: In the passing of Miss McIntyre the Connecticut Hospital Association has lost a faithful member and conscientious officer whose leadership, good judgment and wise counsel was an inspiration to all; be it therefore

Resolved: That the Connecticut Hospital Association records with deep sorrow the death of Mary Ellen McIntyre; and be it further

Resolved: That a copy of this resolution be spread upon the minutes of the Connecticut Hospital Association, and that a copy be sent to her family as a testimonial of the high regard in which she was held by all of her associates in this organization."

The report of the Council on Government Relations, submitted by the Chairman, Mr. Bartine, indicates that as usual Mr. Bartine and his committee are actively engaged in the work of the Council.

The report of the Committee on Uniform Compensation Charges, submitted by the Chairman, Doctor Geeter, was of real value and was accepted by the Assembly.

Doctor Buck reported for the Advisory Committee to the State Board of Nursing Examiners, and Miss Ohlson, Secretary of the State Board of Registration of Nurses, who was present at the meeting, expressed her appreciation of the help which the Advisory Committee has given.

The report of the Committee on Hospital Insurance Policy was then read by the secretary; and after discussion, the recommendations were adopted.

The secretary reported that the handbook of state laws pertaining to hospitals would soon be completed, and the cost would be approximately $5.00 per volume.

Upon recommendation of the trustees, the following persons were elected to *personal memberships*:

James H. Griffiths, President, Charlotte Hungerford Hospital.

J. Raymond Glazier, M.D., Assistant Medical Director, Hartford Hospital

W. Enos Cornett, Business Manager, Hartford Hospital

David H. Martin, Comptroller, Hartford Hospital.

Maurice R. Moore, M.D., Superintendent W. W. Backus Hospital

Carl F. Wieler, Cost Accountant, Grace Hospital

Nellie K. Fergerson, Acting Superintendent, Meriden Hospital.

Mary E. Kelley, Acting Superintendent, Mt. Sinai Hospital

Upon recommendation of the Board of Trustees, it was voted that the Board be authorized to employ counsel at a sum not to exceed $1,000. for the next two years — 1940-1941; and in order to meet the expense it was voted that the active state institutional memberships be assessed at the rate of one-third of the annual regular state dues of the Connecticut Hospital Association for these years.

It was voted that the Connecticut Association will accept applications of any type of institution which the American Hospital Association accepts, determining each individual applicant on his own qualifications.

It was also voted that the personal members who are elected to membership for the State Association after the first day of July of any year shall be declared members with voting power after the beginning of the next calendar year and shall be assessed dues only after January 1 of that next calendar year.

Doctor Allen announced the appointment of Miss Griffin to the Advisory Committee of the Board of Nurse Examiners in place of Miss McIntyre (deceased).

EXCERPTS FROM ADDRESS GIVEN BEFORE THE STATE HOSPITAL ASSOCIATION BY MICHAEL A. CONNOR, COMMISSIONER OF MOTOR VEHICLES

"In 1935 a Commission was appointed to make a study of the Financial Responsibility Act. The Act as it stands today holds that the person who has been convicted for certain serious offenses such as driving while under the influence of liquor, evading responsibility, speeding, etc., must furnish a certificate of financial responsibility — as compulsory insurance, bond, or real estate bond. Few people, however, have been obliged to furnish financial responsibility. Accidents in our state every year appear to make obvious that more people should be included. Last year 1,000 people in our State were seriously injured and 12,000 suffered minor injuries from automobile accidents, these statistics from reports made out by operators. 95% of the persons killed were not motorists, that is did not own a car or were not operators. $17,000,000 receipts last year from operators' licenses. In 1935 hospitals in Connecticut spent $57,300 on persons who had been injured and were not compensated for this expenditure.

"The Committee made extensive study to find out public opinion on compulsory insurance. Insurance companies, Connecticut Hospital Association, Connecticut State Medical Society and different labor groups were questioned as to their views on the subject. It was suggested as a result of the study that it might be feasible to try out a plan that would allow for compensation up to a certain amount, possibly $300.00, that would be for any person that was injured as a result of a motor vehicle accident. This amount to be taken from a fund which was to be created by a nominal fee of $2.00 charged at time of registration of motor vehicle or when securing a license. This to insure immediate and necessary attention to a person injured while the time was being used to investigate the person to blame or who was responsible for the accident. Insured prompt and best of medical aid for such a person. At a later date after conviction, such person was to reimburse that fund. Failure to reimburse fund would involve revoking registration or license.

"In one year there were three million dollars worth of cases under $50.00 with great chance of fraud involvement. Insurance companies urged attention to fraud. Complaint from brokers in insurance business.

"In Massachusetts, the majority is for compulsory insurance.

"There are 550,000 operators' licenses in Connecticut. The State should provide some set-up to take care of this set. The Workmen's Compensation Act works out very satisfactorily. 21 out of 55 unions were for compulsory insurance and 15 more for compulsory insurance on state idea. Others were for continuance of present Financial Responsibility Act, and some had no opinion."

The Commissioner suggests that the Association continue interest in this subject. In the last General Assembly a bill was introduced with $5,000 limit. In his estimation, he hopes the bill will come up again and that we will add our experience to its action.

EXCERPTS FROM AN ADDRESS BY MR. JOHN C. BLACKALL, COMMISSIONER OF INSURANCE, DELIVERED BEFORE THE CONNECTICUT STATE HOSPITAL ASSOCIATION.

"While hospitalization insurance is still in an experimental stage, fourteen insurance companies have entered this field during the past three or four years; and from conferences had with committees of the State Medical Association, it is probable that there will be a non-profit medical insurance plan organized in this state in the not far distant future."

Mr. Blackall spoke of and took note of the fact that the Norwalk and Danbury plans have combined, and he expressed the hope that soon there might be one non-profit hospital plan functioning in the State of Connecticut.

DR. CREIGHTON BARKER ADDRESSES THE GRADUATING CLASS OF THE GRACE HOSPITAL SCHOOL OF NURSING.

The graduating exercises of the Grace Hospital School of Nursing were held at Plymouth Church on the evening of May 27, at which time Doctor Creighton Barker, Secretary of the State Medical Society, delivered the graduating address.

Doctor Barker, in his usual clear-cut manner, pointed out the needs of a continuing educational program to meet the ever-changing and constantly improving methods of medical and nursing care. It was a very impressive address and contained thoughts which the graduates will carry with them for many years.

A JOINT MEETING

The meeting of the Connecticut State Medical Society, held at the Hotel Bond, in Hartford, during May, was joined by two other state organizations — the State Hospital Association, and the Association of Medical Librarians. The State Board of Nursing Registration was represented by the secretary, Miss Ohlson, and there was every indication that the various groups interested in the care of the sick are slowly, but surely, laying the groundwork for a closer coordination of all of the various activities which must enter into this great problem.

It is to be sincerely hoped that other groups will be brought into these meetings in the future.

THE SOCIAL SERVICE DEPARTMENT IN THE HARTFORD MUNICIPAL HOSPITAL

In a Municipal Hospital where all the patients are either receiving relief or are in that marginal income group which is able to secure the minimum necessities of life and maintain their financial independence until some extraordinary expense such as medical care comes along, there are proportionately more patients needing social service help. The Social Service Department of the Municipal Hospital is an integral part of the hospital, and its services are considered essential to the adequate and complete care of hospital and clinic patients.

The chief function of the social service department is to help patients confronted with medico-social problems — that is, problems of illness in which social factors are a contributing cause of illness or present obstacles to the fullest possible recovery of the patient and his adjustment within his family group and in the community. The method of obtaining this purpose is called "case work," a study of the social situation of the individual patient and working out his medical social problems with him and his physician.

The social worker is a member of the medical team. She makes rounds with the doctor and nurse when they examine the patients, discuss their medical records with the x-ray and laboratory reports and recommends treatment. At this time she brings to the doctor pertinent social information which will enable a more adequate understanding of the general health problems of the patient. The social worker also plans jointly with the doctor for the patient's after care and readjustment in the community. When such a plan has been evolved, the social worker plans with the patient and his family for changes in his home condition, his work, or his school which will enable him to keep well. It is poor economy for the community to provide a long and expensive period of hospital care for a patient and then let him go back to the very same conditions which brought about his illness. The social worker understands the significance of disease and the importance of treatment. She takes the time which the busy staff doctor cannot, to explain further to bewildered patients and their frightened families what is the matter, and what must be done, and to work out with them how they can carry out the doctor's recommendations.

The case of Betty, a nine year old colored girl, who was admitted to the hospital with diabetes, illustrates the role the social worker played in helping to carry out an effective plan of treatment. The doctor said that when Betty was ready for discharge from the hospital, it would be necessary to carry out a complicated diabetic regimen involving a carefully prepared and weighed special diet, taking of insulin and testing of urine. Early in her period of hospitalization the patient's condition was explained to and discussed with the mother, who was going to have to assume the major responsibility for her care. It was discovered that Betty was the oldest of five children, and that the family was receiving assistance from the Welfare Department. This meant that the mother was going to need considerable help in learning to carry out this program. While Betty was in the hospital, it was arranged for her mother to come in to watch the nurse administer the insulin and test Betty's urine. Appointments were made for her to discuss with the dietician the patient's diet and how to measure and weigh the right quantities, so that by the time Betty was ready for discharge, the mother was well acquainted with the program of care. More than this, it was felt that Betty was old enough to help with her own care, and that this would be the best way of securing her cooperation in following the prescribed diet. Another important factor was to encourage Betty to be as normal as possible and not to become different from other children because of her diabetes. With these two things in mind it was arranged for her to go to a special camp for diabetic children when she was discharged from the hospital where she would see other children with the same restrictions as hers, and also learn more of caring for herself. When she returned home, the visiting nurse was asked to help the mother at home for the first few days until the mother had gained confidence in giving the insulin herself, and extra allowance for special food was secured through the Welfare Department, arrangements were made with the school for Betty to have her mid-morning and afternoon crackers, and to come home early at lunch time so that her program could be carried out according to schedule. She and her sister later were given dancing slippers and joined a dancing club in a nearby neighborhood house. Close supervision has been necessary and frequent difficulties have arisen because Betty did not stick to her diet. On one occasion a reward system was instituted with prizes when the patient's urine was sugar free indicating that she had not eaten any candies or sweets over a certain period. The mother has been taught to make diabetic ice cream, and diabetic candy has been provided on occasion as special treats. On the whole Betty has done well, and is at present in school doing good work and living a normal happy life. Here the social worker's part in treatment was essential not only in helping to arrange for the actual diet and medication, but in taking into consideration the emotional and psychological reactions of both Betty and her mother.

Often the medical social worker does not work alone, but in cooperation with another welfare agency, which may also be assisting the patient or his family. In such cases the medical social worker interprets to the outside agency the patient's condition, and the doctor's recommendations, and that agency helps the family make the necessary readjustments. I purposely use the word "interprets," for it is little help if the medical social worker tells the family welfare agency that Mrs. Kelly has mitral regurgitation. The worker can easily look up in the medical dictionary and discover that this is a heart condition, but still she does not know what this means in terms of Mrs. Kelly as a person. But if the medical social worker tells the family worker that Mrs. Kelly has a heart condition which restricts her activity to the extent that she can no longer take in washings, and that she can no longer climb three flights of stairs to her flat, but must move to a first floor, and that little improvement in her condition can be expected, then the worker has a basis on which to work out a suitable plan to help Mrs. Kelly.

Because the hospital division of the Welfare Department is responsible for the determination of eligibility for admission of patients to the hospital, and many of the patients in the hospital and clinic are also clients of the Welfare Department, the working relationship between the the social service department and the Welfare Department is particularly close.

The social service department is organized according to the medical division of the hospital; that is, one worker is responsible for the Medical Service, one for the Pediatric, Obstetrical, and Gynecology Services, a third for Orthopedic and Surgery, and a fourth for the Psychiatric Service. The same worker is able to follow a patient both in the clinic and in the hospital.

The cooperation of the administration, medical and nursing staffs is essential for the effective functioning of the social service department. The social service department of the Municipal Hospital has been fortunate in that the staff of the hospital has been cognizant of the social problems with which many of the patients are faced and has cooperated with the social service department in working out these problems for the best interest of the patients.

EDITORIAL NOTE

We are indebted to Brough, of Norwalk; Bartine, of Bridgeport; Loasse, of Greenwich; Buck, of Torrington; Sweeney, of Willimantic; Ryan, of Hartford; and to Miss Griffin, of Danbury, for the material for these pages of the Journal.

May we become indebted to the other institutions of our state.

SECTION ON Orthopedic Surgery

Doctor Philip D. Wilson

On May 22 at the Connecticut State Medical Society's annual meeting Doctor Wilson addressed the Orthopedic Section on "Modern Treatment of Low Back Pains and Sciatica." In the absence of Doctor M. K. Lindsay, Doctor Maurice M. Pike presided. The fundamental principles and specific forms of diagnosis and treatment were exceedingly well portrayed by Doctor Wilson. His profound knowledge of the pathological processes at work in producing these disturbances added to the academic as well as practical value of his paper. What physician is not vitally interested in the modern treatment of low back pain and particularly that accompanied by sciatic neuralgia? And yet, many of the othopedists of the state were absent from this meeting. The subject and speaker were selected with considerable care, hoping it would bring out the membership.

Connecticut Fracture Committee

Doctor Paul P. Swett presided at the Connecticut Fracture Committee Meeting of the American College of Surgeons, Hartford, on April 25. A particularly interesting discussion was developed in the morning by such outstanding members interested in safety as Michael A. Connor, Commissioner of Motor Vehicles, Edward J. Hickey, Commissioner of State Police, Stanley H. Osborn, Commissioner of Health, and L. M. Thompson, Assistant Director, National Red Cross. Fred W. Orr, Executive Vice-President of the Connecticut Chamber of Commerce gave his usual pep talk on safety. The stimulation to the committee which these speakers produced will bear fruit during the ensuing year.

Doctor Paul P. Swett has served as chairman of this committee since its inception and has served well. His charming personality and enthusiasm as well as his obvious mastery of the subject of fractures has given to this committee national standing with interest focused upon it from many other states in the union. Doctor R. M. Yergason, the committee's able secretary, has aided and abetted this work, often maintaining the spark of enthusiasm when it seemed to be at a low ebb. Doctor Swett, because of the press of circumstances, saw fit to resign from the committee chairmanship. Doctor R. M. Yergason was the logical successor and was elected to this post. The committee will back him as it has backed Doctor Swett and should go on to a completion of this major safety movement emanating from the American College of Surgeons.

The scientific papers read in the afternoon by several members of the committee were interesting and enlightening. The guest of the committee was Doctor A. P. Aitken of Boston who read a paper on "Fractures Involving the Epiphyses." From his studies he reports fractures of the epiphyses will influence aftergrowth depending upon the position of the fracture line in relation to the epiphyseal line. Those fractures that are distal to the epiphyseal line and extending along it may not disturb growth but those located proximally to the epiphyseal line and extending into it and along it frequently influence growth unfavorably. He made note of several exceptions to this rule but by and large it seems to hold, according to his paper.

It was learned that Doctor Roy V. Sanderson who was to read a paper at the meeting could not do so because of ill health. The committee regretted his absence and expressed the hope that he would soon be well.

Annual Convention of the National Society for Crippled Children, Asheville, North Carolina.

From October 5th to 10th in Asheville, North Carolina, the National Society for Crippled Children will hold its annual convention at which time several interesting papers on orthopedic subjects will be presented with particular emphasis on coordinating lay and professional services in the orthopedic care and treatment of crippled children. These meetings are always of great value, stimulating those who attend to greater service in their communities. All members of the orthopedic section are invited to attend.

Accident Toll 1939.

"Safety Education" March, 1940, reports the survey for the nation's 1939 accident cost:

Killed	— 93,000
Injured	— 8,800,000
Economic Loss	3,300,000,000

Traffic accidents during this time produced 90% of the injuries which resulted in some permanent disability.

Survey of Physically Handicapped.

Recently reports from the State of Pennsylvania show that the ratio of handicapped physically is 7 males to 3 females. Three-fourths of all handicapped individuals have no more than a ninth grade education. This report also shows that one-third are unemployed because of their handicap and that more than one-half of the disabilities result from disease. Smaller business enterprises were more ready to employ the handicapped than were the larger ones.

Another survey completed in Rochester, New York, shows that there is little increase or decrease in the number of crippled children during the past five years. Both tuberculosis and infantile paralysis show a definite decrease but crippled conditions caused by accidents were increasing, one apparently balancing the other. The ratio established three crippled children to every thousand of population.

Notice

A directory of camp and summer activities for crippled children in the United States is available to any physician or agency who will write to the International and National Societies for Crippled Children, Elyria, Ohio.

Three kinds of People

There are three kinds of people in all organizations and the orthopedic section is no exception.

1. Rowboat people: Always need to be pushed or shoved along.

2. Sailboat people: Move along when a favorable wind is blowing.

3. Steamboat people: Move along continuously through calm or storm.

Let's be steamboat people in this section.

SECTION ON Industrial Health

About forty industrial physicians and surgeons attended the organization meeting of the Section on Industrial Health held in conjunction with the Annual Meeting on May 22. Doctor Clifford Kuh acted as chairman.

By-Laws were adopted, as well as a platform of guiding principles for industrial health promotion in Connecticut. Doctor Albert S. Gray gave a brief talk concerning the new plans for expanding the activity of the Bureau of Occupational Disease of the State Department of Health.

Officers elected were: Eugene F. Meschter, M.D., Stamford, Chairman; Edward G. Hurlburt, M. D., Bridgeport Secretary-Treasurer. Doctors who desire to become affiliated with the Section should communicate with Doctor Hurlburt.

Guiding Principles for Industrial Health Promotion in Connecticut

The following are advocated:

1. Recognition of the whole man, physical, mental and emotional, as an entity in the scheme of production.
2. Evaluation of the efforts of all groups, organizations and agencies to study industrial conditions in the United States and particularly in Connecticut, with the view of applying to Connecticut successful work in other states, of evaluating specific studies within the State of Connecticut, and of ascertaining how best to coordinate, and cooperate with, the work of all groups and agencies.
3. Origination of new studies for Connecticut, if and when feasible.
4. Judicious effort to obtain application of needed changes in industrial practice.
5. Due regard for supportive state legislation.
6. Particularly the dollars and cents evaluation of the application of improved procedures in lowering compensation costs, reducing absenteeism, and other measurable effects, including cost comparisons under conditions before and after introduction of improved procedures.
7. Withal some unified plan or appeal which will encourage all interested groups wholeheartedly and even with self-sacrifice, if necessary, to do the best possible job for Connecticut.
8. Finally, the recognition of the principle that the preservation and promotion of the health of workers is essentially the responsibility of industry itself, that it is vital for industry to demonstrate that it can of its own accord — with the cooperation of government, but without restricting or handicapping governmental legislation — further the well-being of workers as part of a broader program to solve the numerous problems which lie essentially within its own domain.

-The- General Practitioner's Forum

Baldwin recently reviewed a series of several thousand Tuberculin tests. His conclusions are interesting.

The Vollmer patch test is a useful procedure. It is safe and has the attractive advantage that no needle is required. Since it is equivalent to an intra-dermal test of .01 mg. of Old Tuberculin, its use should be limited to those cases in which a diagnosis of tuberculosis is strongly suspected. For routine testing, the intra-dermal Mantoux is more definitive. The initial dose is 0.1 mg. If this is negative, a 1 mg. dose should be given. In rare instances a 2 mg. dose may be required. A negative result is practically conclusive evidence that tuberculosis is not present.

* * * *

In cases of rapidly recurring or prolonged convulsive seizures, Wechsler, J.A.M.A. June 1, 1940, recommends the intravenous injections of paraldehyde in 1 cc. doses. He has used it with impunity over a period of twenty years with excellent results. In line with this procedure is the intravenous use of morphine in cases of sudden severe pain where prompt action is wanted. Usual dose is one-sixth of a grain. It has been an old standby.

In a paper based on the review of histories and follow-up records of 2067 cases of fracture of the extremities in children under 12 years of age, Beekman and Sullivan conclude that treatment in these cases differs from that used in the adult. An analysis of this paper reveals some interesting and helpful facts.

It was found that the upper extremity was the site in 75% of the cases with only 25% in the lower. The bone most frequently involved was the radius, followed in order by the humerus, tibia, femur and clavicle. Fractures of both bones in the forearm or leg were relatively uncommon. Primary union occurred in all cases; cross-union occurred in one case. No complicated form of treatment was used. Manipulation, plaster casts or splints and skin traction were the methods of choice. Open reduction was mentioned only as an exceptional procedure in certain selected cases: i.e., fracture and torsion of the epicondyle of the humerus. Skeletal traction was neither used nor recommended. Greenstick fractures were always completed.

Accurate anatomical reduction was not essential for good results, except in supracondylar fractures of the humerus. In these cases because of potential alterations of the carrying angle, reduction must be meticulous. As a final statement, they observed that nature reconstructs the basic architecture of the bone in poorly aligned cases. As proof they offered x-ray studies made at the time of injury, after reduction and several years later. They were convincing evidence that conservative treatment is most satisfactory.

* * * *

Carpenter and Milton in the Am. J. Public Health call attention to the fact that gonorrhea, treated with sulfanilamide or its derivatives, cannot be called cured unless repeated tests and cultures are negative. They observe that too many cases, becoming symptom free, are discharged as cured, only to become potential carriers.

Pelouze, in a recent article, makes practically the same observation. His recommendations: Treatment should be a combination of local irrigations and sulfanilamide. It should be continued for the full six to eight week period. It should be followed by the usual alcohol and sex stimulation tests. Final pronouncement of cure after repeated negative smears and cultures.

T. P. R., M.D.

THE NEURO-PSYCHIATRIC INSTITUTE OF THE HARTFORD RETREAT REPORT OF THE BOARD OF MEDICAL VISITORS TO THE BOARD OF DIRECTORS

Those of us who have been in medicine for a quarter of a century or more have seen a great many advances within the profession. The individual physician has had to adapt himself to these new conditions, for to stand still was to fall behind. This is equally true of a hospital such as the Institute; each passing day has brought new theories, new practices, new methods of approach. To analyze these carefully, selecting the sound and discarding the ephemeral is a matter requiring discreet judgment and the ability to withstand the enthusiasms that sometimes accompany new therapies. We are pleased that the Institute has taken a temperate middle course, applying the basic test of common sense, keeping an open mind, but refusing to follow the bell—whether of each new therapeutic fad that has appeared on the horizon.

It has seemed to us that one of the greatest possible advances in psychiatry would be a general appreciation by the lay public of the desirability of early treatment in mental disorders. Much progress has been made along this line and not a little of it has been due to the general practitioner's growing knowledge of what the modern psychiatric Hospital may do to cooperate with him in the care and treatment of patients.

For a long time this Board has been interested in the development of these close relations between the hospital and the general practitioner. It is our belief that he is the best possible avenue through which to route psychiatric information and mental health practices to the general public. At the same time, we realize that the family doctor, the general practitioner, is the busiest of all professional men. He does not attend psychiatric meetings, nor is it usual for him to attend meetings of social workers, mental hygienists or others who preach the doctrine of mental health to the public. Furthermore, he is a bit suspicious of those who have a mission to perform because, being practical-minded, he knows that most reformers see only the horizon of their own particular project and seldom the broad sweep.

We believe that the several practices inaugurated and carried out by the Institute, and designed to keep in close contact with the general practitioner, are overcoming these difficulties. We refer to the practices of sending progress notes and complete case histories to all referring physicians, to the mailing of abstracts and translations from the Science Library, and encouraging physicians to maintain their close contact with patients even after they have come to us for treatment.

Although the general practitioner or the surgeon may not be particularly interested in psychiatry, he is interested in his patients. Consequently, when he refers a patient to the Institute and receives frequent progress reports with detailed explanations of the symptoms of the illness, there is a definite absorption of psychiatric knowledge. Repeated eight hundred times a year —the number of patients treated at the Institute — and it is obvious that this medium of informing is an ever widening one.

The distribution of psychiatric abstracts and translations is another practice of which we heartily approve. At the time of our reorganization immediate steps were taken to augment the scientific literature made available to the staff of the Institute; translators went through literature of foreign origin so that all would be cognizant of developments abroad as well as in this country. The group of interested recipients of these digests of foreign literature grew until it now includes not only our own Medical and Consulting Staffs, but an ever-widening circle of psychiatrists in other parts of the country and abroad, general practitioners and men in other specialites.

For three years now these abstracts and translations have been distributed rather widely and we have found the physician in general practice to be eagerly interested in these frequent reports on psychiatric advances. That they have fulfilled a real need seems indicated by the fact that recently more than 40% of the men in general practice or other specialties to whom they have been sent went to the trouble of requesting that they be continued on the mailing list for the receipt of this material.

Supplementing this, the Institute for nine years has made every effort to hold the interest of physicians referring patients to it. Eschewing the tendency to cut off all contact between the referring doctor and his patient on admission to the hospital, the Institute has encouraged this continued relationship, urging personal visits to the patients, and stimulating his interest in general. We believe this is not only a sound way to maintain a cooperative relationship between hospital and physician, but that it redounds to the interest of the patient by providing a continuity of care in the post-hospital phase.

None of these practices are startling in themselves, but taken together they do create a constructive attitude within the profession and from the standpoint of preventive psychiatry we consider this phase of medical education within the profession to be the most important.

There is a chain of circumstances that one can follow, link by link: early referral means the optimum of speedy recovery for those who are ill; early referral depends primarily upon the attitude of the general practitioner, the neurologist and the psychiatrists; the attitude of the general practitioner, the neurologist, and the psychiatrist depends largely upon the hospital's attitude toward them.

In the last analysis, the most effective psychiatry is that which takes the referring physician into its confidence and makes of him a working partner in the struggle against one of our greatest public health problems.

It would seem to this Board, that the policies of the Institute along these lines should produce satisfactory results.

George Blumer, M.D., New Haven
D. Chester Brown, M.D., Danbury
B. Austin Cheney, M.D., New Haven
James D. Gold, M.D., Bridgeport
Frederick G. Graves, M.D., Bethlehem
Thomas P. Murdock, M.D., Meriden
Elias Pratt, M.D., Torrington
George M. Smith, M.D., Pine Orchard
Walter R. Steiner, M.D., Hartford
Daniel Sullivan, M.D., New London

Hartford, Connecticut
April 29, 1940.

Sixteenth Clinical Congress
of the
Connecticut State Medical Society

New Haven, September 17, 18, 19, 1940

The registration fee for the 1940 Congress will be $2.00. This fee admits to all sessions of the Congress, which this year will be held, both morning and afternoon, at the Sterling Law Buildings.

The plan of the program will be somewhat different this year. The addresses of the guest speakers will be thirty minutes in length, and some of these will be presented at the morning and some at the afternoon sessions. The five minute talks will be presented at the end of the morning sessions.

Luncheon will be served, at a moderate price, in the Law Buildings each day. At these luncheons, one of the guest speakers will address the Congress, in a question and answer session.

The program committee is planning again to present two or more three day courses, which registrants may attend by paying an additional fee of $1.00. Further details of these courses will appear in later announcements.

In addition to the section meetings announced in this issue of the Journal, several of the sections are making plans for section meetings or dinners. These will be announced when the plans are completed.

The Women's Medical Society of Connecticut will hold its fall meeting at the time of the Clinical Congress. All women in medicine will be welcome.

Parking of automobiles for members of the Congress will be unrestricted as to time in the vicinity of the meeting place. Continuous telephone service will be maintained.

Early registration will facilitate the work of the committee and save time for you at the Congress. In the pages of this *Journal* you will find a registration card. If you expect to attend the Congress, please fill out the card now and return it with your check for $2.00 payable to the Connecticut Clinical Congress. This should be sent to the office of the Connecticut State Medical Society, 258 Church Street, New Haven.

Maurice J. Strauss, M.D.,
Chairman of the Committee on Publicity and Registration

. . . PROGRAM . . .

September 17

9:30 A.M. Newer Developments in the Treatment of Diabetes.
Elliott P. Joslin, Boston

10:00 A.M. Complications of Pregnancy.
Nicholson J. Eastman, Baltimore

10:30 A.M. Treatment of Coronary Artery Diseases
Herrman L. Blumgart, Boston

11:00 A.M. Chemotherapy of Streptococcus Empyema.
Grover F. Powers, New Haven

11:10 A.M. Use of Vitamin K in Hemorrhagic Diseases of the Newborn.
Howard W. Brayton, Hartford

11:20 A.M. Diagnosis of Pneumococcus Types from Nasal Washings.
James D. Trask, New Haven

11:30 A.M. Contra-indications to Marriage from the Psychiatric Viewpoint.
Eugen Kahn, New Haven

11:40 A.M. What We Can Learn from Gastroscopy.
James Flexner, New York

11:50 A.M. Sulphathiazole and Related Compounds.
Francis G. Blake, New Haven

12:00 — 2:00
Luncheon
Elliott P. Joslin, guest speaker in a question and answer symposium.

2:30 P.M. Office Procedure in Anoretical Diseases.
Harry E. Bacon, Philadelphia

3:00 P.M. Peripheral Vascular Diseases.
Leland S. McKittrick, Boston

3:30 P.M. Conservative Treatment of Fractures of the Neck of the Humerus.
John J. Moorhead, New York

4:00 P.M. Significance of Low Back Pain.
Frank R. Ober, Boston

4:30 P.M. Tumor Conference

SECTION MEETINGS

8:00 P.M.

Section on Anesthesia
Section on Proctology

September 18

9:30 A.M. Diet and Nephritis.
Soma Weiss, Boston

10:00 A.M. The Epilepsies.
Wilder G. Penfield, Montreal

10:30 A.M. The Clinical Use of Estrogenic Hormones.
Raphael Kurzrok, New York

11:00 A.M. Treatment of Delirium Tremens.
Charles M. Krinsky, New London

11:10 A.M. Treatment of Spinal Injuries Which Involve the Spinal Cord.
Bernard S. Brody, New Haven

11:20 A.M. Convulsions in Children. Diagnostic Routine and Treatment.
William J. German, New Haven

September 18 (Cont.)

11:30 A.M. Clinical Interpretation of Blood Iodine Levels.
Edwin F. Gildea, New Haven
11:40 A.M. The Relief of Intractable Pain by X-ray Therapy.
Hugh M. Wilson, New Haven
11:50 A.M. The Use of Intravenous Magnesium Sulphate in Convulsive States.
Daniel C. Darrow, New Haven

12:00 — 2:00
Luncheon

2:30 P.M. Dry Clinic on Pyelo-nephritis.
Soma Weiss, Boston
3:00 P.M. Clinical Pathological Conference.
Milton C. Winternitz and Staff, New Haven
4:00 P.M. Tumor Conference.
Charles L. Larkin, Waterbury

SECTION MEETINGS
8:00 P.M.

Hezekiah Beardsley Pediatric Club
Section on Physical Therapy
Section on Neurology and Psychiatry

September 19

9:30 A.M. Treatment of Chronic Arthritis with Special Reference to The Use of Gold Salts.
M. Henry Dawson, New York
10:00 A.M. Treatment of Peptic and Jejunal Ulcers.
Frank H. Lahey, Boston
10:30 A.M. Intravenous Drip Chemotherapy.
Harold T. Hyman, New York
11:00 A.M. Diagnosis of Cancer of the Cervix.
Thomas H. Russell, New Haven
11.20 A.M. Phsyiology of Cold Therapy
Henry G. Barbour, New Haven
11:30 A.M. Present Status of the Clinical Use of Cold Therapy.
Julian B. Herrmann, New Haven
11:40 A.M. Ligation of the Ductus Arteriosus.
Robert E. Gross, Boston
11:50 A.M. The Contribution of Orthopedics to the Early Treatment of Poliomyelitis.
A. Lewis Shure, New Haven

12:00 — 2:00
Luncheon
Frank H. Leahy, guest speaker in a question and answer symposium.

2:30 P.M. Differential Diagnosis of the Tumors of the Breast.
George T. Pack, New York
3:00 P.M. Clinical Use of Digitalis.
Harry Gold, New York
3:30 P.M. Gas Inhalation Therapy.
Alvan L. Barach, New York
4:00 P.M. An Approach to the Problems of Adult Life Through Industry.
Clarence D. Selby, Detroit
4:00 P.M. Tumor Conference.

Annual Reports

OF THE CONNECTICUT STATE MEDICAL SOCIETY 1939 - 1940

(Continued from Vol. IV, No. 5)

PRESIDENT'S REPORT

To the Members of the House of Delegates:
Gentlemen:

The past year has been notable in the annals of the Society. Despite the fact that the Legislature was not in session, there have been many activities radiating in many directions.

The outstanding accomplishment has been the consummation of the arrangements for engaging your full-time executive secretary. This arrangement will result in full dividends to the Society.

The work of all your committees has progressed satisfactorily and the spirit of willingness to go along and turn the wheel has been evidenced by almost every member.

The membership of committees has been well spread throughout the Society with the selection of men, when possible, on account of aptitude for special service and in the hope that everyone would add his help in the business of medicine.

While it may be out of order at this time, I desire to comment on the sincerity and diligence of the Council in carrying on the administration of the Society in the interim between sessions of the House of Delegates and to say it has been a full experience to have been a member of this board for the last two years.

As your president, I participated in the following:

Presided at the following:
- First session of 1939 Clinical Congress, September, 1939.
- The Special Session of House of Delegates, September, 1939.
- The Mid-Winter Dinner Meeting, Dr. Morris Fishbein, speaker.
- Meeting of County Secretaries, New Haven, February 23, 1940.

Addresses:
- Laying of Corner Stone, Southbury Training School, October 5, 1939.
- Connecticut Conference of Social Workers, October 26, 1939.
- Connecticut Pharmaceutical Association, February 7, 1940.
- New England Health Institute, April 18, 1940.

Meetings attended and greetings extended:
- Corner Stone Ceremonies, new building of State Hospital, Middletown, September 8, 1939.
- Public Meeting of Hartford City and County Medical Society and Information Bureau, Foster Kennedy, speaker, October 16, 1939.
- Annual Meeting of American Bacteriologists, New Haven, December 29, 1939.
- Celebration of 100th Anniversary of founding of first dental school, New Haven Dental Association, New Haven, February 29, 1940.

Special Meetings:
- Represented Society at meeting of Hartford Tuberculosis and Public Health Society, October 26, 1939.
- Represented Society at organization meetings of Connecticut Tuberculosis Association.
- Represented Society at meeting with physicians and pharmacists to discuss benzedrine and other drug sales, New Haven, December 6, 1939.

Council Meetings:
- All Council meetings were attended.

County Meetings;
- One of the many pleasant traditions handed to the president is the custom of visiting the County Society meetings and making the acquaintance of the members. This is not a task but a great pleasure. All the fall meetings of the constituent societies were attended. In April it is regretted that only four counties were visited.

In August, Governor Baldwin appointed your president a member of the Tuberculosis Commission to fill the unexpired term of the late Stephen J. Maher, M.D. This honor is greatly appreciated.

This report is submitted with the cognizance of the great honor you have bestowed on me and with an expression of thanks to the members of the Society for granting me the great privilege of serving you.

Respectfully submitted
JOSEPH I. LINDE, M. D., President.

* * * *

SECRETARY'S REPORT

During the year just past The Connecticut State Medical Society has enlarged the scope and usefulness of its activities and strengthened its position in many fields. It has been an important year for the Society and one that should mark the beginning of a finely productive period in our history.

The Society is a thoroughly democratic organization and must rely upon all of its members for inspiration and accomplishment. There is a rapidly increasing interest in the Society's affairs on the part of its members and this brings fresh encouragement to those of us who are concerned with the Society's management. The Secretary is here pleased to acknowledge the help and cooperation that he has received from the officers and members of committees. I wish especially to bring to your attention the faithful and time-consuming consideration that the Council has given to your affairs. Few members of the Society realize the amount of work that the Council is now called upon to do and every one of you owes a great debt to these gentlemen who give so generously of their time. To the Chairman of the Council, Doctor James Douglas Gold, I express my personal appreciation of his honest good judgment and wisdom which has guided the Council for many years.

The many and varied enterprises of the Society require service by specially qualified committees and it is your Secretary's plan always to meet with these committees, become familiar with their programs and guard against overlapping function without making proposals as to their policies. I will briefly survey the progress of the more important committees during the year.

The Public Health Committee, under the Chairmanship of Doctor Joseph H. Howard, has continued the work and progressive program that it has previously followed. Government's participation in the field of medicine seems to be increasing rather than waning and the importance of this committee, serving as it does in an advisory capacity to the State Department of Health, is becoming more and more real. We are fortunate in this State in enjoying a warmly cooperative relationship with the agencies of government, and so long as it continues, and this committee functions as it has, there should be little cause for misgiving with regard to government interference. It is a strong and important agency of the Society.

You may view with satisfaction the work being done by the Tumor Committee under the chairmanship of Doctor Larkin. The accomplishments of this committee have received wide and favorable comment and some day we will look back at its efforts and attainments with the same fine pride that we now take in the early pioneering carried on by the Society in the care of the insane, the feebleminded and the tuberculous. If anyone wants to know what the State Medical Society does and what it stands for a review of the activities of the Tumor Committee should be sufficient answer by itself if nothing else were done.

The Clinical Congress continues to be a valuable educational contribution to the field of applied medicine. Attendance at the Congress has remained just about static for the last two years, declining from its peak of 1937. Some competition has been encountered from other postgraduate assemblies patterned after our own Congress, and opportunities to attend other scientific meetings. But the Clinical Congress Committee is not content to accept as final that the maximum attendance at the Congress has been reached and fresh efforts are being brought by this committee to increase the popularity and usefulness of the Congress.

The special Committee on Prepaid Medical Service of which Doctor Samuel Harvey is Chairman, has quietly explored an area of new social significance. Many states are concerned with the operation or development of plans for prepayment for medical service and Connecticut is not backward in its approach to the problem. There are many philolophies concerning voluntary medical insurance and there are also many hazards in its operation. This committee clearly sees the question that confronts it and has approached it with wisdom and discrimination. We are cautious people in Connecticut, not always moved by the excitement of others. If this Society finally decides to develop and foster a prepayment plan for providing medical service it will be after careful and mature deliberation. This committee, through its formal conferences with industry and labor, and informal conversations with other smaller groups, has demonstrated in striking fashion that organized medicine in Connecticut is not unmindful of its social responsibilities.

The Society has made some progress in the field of public relations. We have developed favorable and productive cooperation with the public press which is becoming more and more understanding of our aims and the Secretary believes that there is an increasing willingness on the part of the public to view with favor the whole of medicine in Connecticut. In these times the importance of this cannot be overestimated and our efforts in this connection should be thoughtfully conceived and continuously followed. The quality of medical care in this State is relatively high and our people want to believe in their doctors but to maintain and strengthen that belief in the face of insidious outside influences calls for a broad and honest program of public relations. People are more interested in medical affairs than even before and there is a steadily increasing demand from lay organizations to be informed on medical and medical-social topics. It has not always been easy to satisfy the demand for speakers to present discussions of these topics and one of the most pressing problems that confronts the Society at present is the development of a speaker's bureau, made up of members who can intelligently set forth such subjects before women's clubs, service groups, and community organizations. It is hoped that productive steps in this direction may be taken during the year that lies ahead. Publicity is at present handled from the Secretary's office and it is probable that it should continue to be so. There must be, however, among our members, personnel for an active, self-reliant committee to whom the Secretary may turn for advice and guidance in developing our public relations program. I earnestly ask you for such assistance.

The Connecticut State Medical Examining Board, while actually an official state agency, is so intimately connected with this Society that it has always been considered as one of our committees.

This Board works quietly and effectively in safeguarding the quality of medical care in the State and although it is impossible to measure accurately its effectiveness, it does seem reasonable to assume that the high standard maintained by this Board has been the most important factor in elevating the quality of medical care in Connecticut. It was the Secretary's privilege to attend the National Conference on Medical Examination and Licensure in February with Doctor Murdock. It was my first experience at such a conference and as I sat through its meetings I could not help but feel that Connecticut had been especially fortunate in the progress it had made in medical licensure. Working quietly as it does there are not many of us familiar with the problems that confront this Board. Perhaps it is better to have it so, but changing time have brought to it fresh problems that have to do with the refugee physicians, graduates of foreign medical schools, and efforts to circumvent some of the wise rulings that the Board has made. Not only the members of this Society but every citizen of the State should realize the responsibility which this Board faces, and the importance of the careful selection of its personnel and the guarding of its integrity.

The continued close cooperation of this Society, through its Committee on Hospitals, with the Connecticut Hospital Association, is of great significance. In no other state has such a useful working arrangement been developed. The problem of medical care is so closely related to the hospital field that only by mutual understanding will we arrive at the answer.

The Committee on Industrial Health under the chairmanship of Doctor Clifford Kuh, has progressed with its program, and the conference groups with the State Manufacturers' Association that is being developed should provide a ready means for the consideration of health problems arising in Connecticut industry.

The Journal, concerning which you will have a detailed report from the Editor, was an undertaking the magnitude of which is not understood by all of our members. It has survived the hectic early days of organization, has prospered financially and now looks forward to a period of development and growth. I want to express my personal appreciation for the ever present cooperation that I have received from the Editor and his associates.

As the activities of the Society expand the position of the officers of the County Associations, especially the Secretaries, becomes more important. To attain its maximum effectiveness the State Society should include in its membership every eligible physician in State. Because of the method of electing members to the State Society through the County Associations the County Secretaries are the key men in this connection and in developing interest in the Society's activities in the smaller and more intimate fields. It is well recognized that the duties of the Secretaries in the larger counties make considerable demands upon their time, but theirs is a very definite responsibility and should be viewed clearly by them and the office should not be undertaken by anyone who is not willing to give the time, effort and thought that is required. Here and there one hears the comment that with the new program of the State Society organization the County Associations may gradually lose their identity. This is far from the fact. As the State Society grows in importance there should be collateral growth in importance and influence on the part of the County Associations. As far as your Secretary knows the idea that the State Society should supercede the County Associations has never been expressed. It is the intent and purpose of the officers of the State Society to be of stimulating help to the county organizations and to cooperate with them in every way in making the county units more effective in their respective areas.

Although it is somewhat of a personal enterprise it is so intimately connected with the State Society that it seems proper to mention in here. I refer to my services in connection with the Personnel Department of the State government. These services have had to do with the selection of physician employees for the State. I have called freely upon many members of the Society to serve as members of examining boards and their cooperation and skill has been generously given. It is an unusual opportunity for this Society to be of public service and is a responsibility that we should gladly accept. As time goes on and the burden of this obligation increases it may well be that the Society should seek the opportunity to establish an advisory committee in the field of professional employment for the Personnel Department.

With the changing pattern of the Society's organization and functions it has been necessary to frequently revise the By Laws during the past few years in order that they would be compatible with new administrative procedure. So that these changes might be brought about in

	New Members	Reinstatements	State trans. in	County trans. in	Death	Res.	Dropped	State trans. out	County trans out
Fairfield	27	4	2	6	8	4	13	4	2
Hartford	14	1	2	2	7	4	5	—	2
Litchfield	2	—	—	1	2	—	1	—	—
Middlesex	2	1	—	1	—	6	—	—	1
New Haven	26	5	6	1	12	14	8	7	3
New London	5	—	—	2	2	3	—	2	—
Tolland	—	—	—	1	—	—	3	1	1
Windham	1	—	—	1	—	—	1	—	—
Totals	77	11	10	15	31	31	31	14	9

Total membership May, 1939 — 1757

Total membership May, 1940 — 1766

COUNTY TOTALS

	1939	1940		1939	1940
Fairfield	379	391	New Haven	517	518
Hartford	533	534	New London	119	120
Litchfield	78	77	Tolland	22	18
Middlesex	70	67	Windham	39	41

an orderly fashion the Council, of its own volition, appointed a Committee on By Law Revision to advise concerning the changes that from time to time appeared to be required. This Committee, under the chairmanship of Doctor Campbell, was an informal one and served only as advisors to the Council. The time has now come it seems to me when the By Laws should receive a thorough scrutiny and recodification and to that end I would recommend that the Council be directed to appoint a Committee on By Law Revision with instructions to report to the House of Delegates at its annual meeting in 1941.

This report would not be complete without an acknowledgment of the unselfish and interested help that has been given by the secretaries employed in my office, and the interested and alert attitude that they display. I am grateful to them and to Miss Landry in the office of the Hartford County Association, and to Miss Munroe, secretary to the State Commissioner of Health, for all that they have done.

CREIGHTON BARKER

* * * *

REPORT OF THE CHAIRMAN OF THE COUNCIL

The decisions and formulations of policies for an organization such as this, even though founded on the most democratic of principles, must of necessity lie in a small and active group of representatives and that is exactly what your Council is.

Five or six years ago there developed in the Society the beginnings of an idea that our affairs should be carried on in a more business like fashion and that the usefulness and the functions of the Society should be extended. Gradually and with careful inquiry through those years most of the proposals that had been thought desirable for the development of the Society have been accomplished. With the establishment of a full time Secretary's office the organization and transaction of the Society's business and the development of its program will surely be accomplished more consistently and efficiently.

For the past two or three years the Council has met each month and given careful consideration to your affairs. The members of the Council have been faithful in their attendance and I want to thank them for their unselfish service and loyalty to the Society.

The Society is gradually and wisely extending the sphere of its influence into groups and professions that are concerned with the care of the sick. The relationship with the hospitals of the State that was begun three years ago through the Hospital Association, has been further strengthened and the Council approved and took the preliminary steps for a similar close alliance with the nurses organization and the druggists of the State.

Lengthy consideration has been given to the peculiar problems that are arising as the prepaid and insurance plans for providing hospital care become more widespread. Especial attention has been directed toward checking the tendency to include some medical service under these plans, which is contrary to the resolution passed by this House in 1937. Lately the problems have come along with cash indemnity insurance for hospitalization and have been a cause of concern. This subject is now receiving the joint consideration of the Society's Committee on Hospitals and of representatives of the Hospital Association.

Occasionally matters of behavior and professional conduct are brought to the attention of the Council and from Fairfield County came a request for an opinion concerning the use of specialists designations on office signs and the distribution of professional announcements to the laity, and it was the Council's opinion that although local custom was to be considered, in general the use of such practices is undesirable.

A second mid-winter dinner of the Society was held in Hartford early this year at which time Doctor Morris Fishbein, Editor of the Journal of the American Medical Association, was our guest. The dinner was well and enthusiastically attended and it is especially to be noted that a large number of ladies were present. Although these mid-winter dinners are still somewhat experimental it may be well for the Society to consider them as a permanent part of our activities.

With the increase in dues that has been necessary with the expansion of our program the Council has recognized the desirability for making some provision for those members who have contributed to the Society for many years and has finally devised an amendment to the By-Laws which will exempt such members from the payment of dues if they wish such exemption. That amendment is submitted today for your decision.

As the whole of medical organization in American of necessity has become better integrated, closer contact with the American Medical Association, its policies and activities, seems highly desirable for this Society and to accomplish this, the Council is recommeding an amendment to the By-Laws which would add our delegates to the American Medical Association to the Council. By this means it is certain that we will have ready access to the counsels of the American Medical Association and our delegates will be thoroughly and promptly appraised of the opinions and policies of the Society with respect to national affairs.

This report consolidates the reports of the Councilors from all of the eight counties and in those reports I have found nothing but encouraging and interesting comment. Two of the county associations are now having monthly meetings through the winter and increase in interest in the affairs of this Society and the whole of the profession of medicine is apparent on every hand. Several of the county associations have removed from their rolls members who have been chronically delinquent in the payment of dues. For that reason a somewhat unusual number of members were separated from the Society but they have been replaced by new members so that the total membership is almost exactly what it was a year ago. In Litchfield County the membership is the largest it has ever been.

There will be some changes on the Council during the coming year. Doctor Leak, who has been the Councilor from Middlesex County since 1932, did not seek reelection and he will be succeeded by Doctor Alfred N. Sweet of Middletown. Doctor Leak has been a valuable and attentive member of the Council during these active years and his services have been appreciated. My own term as Councilor from Fairfield County has also come to an end and I will be succeeded by Doctor Samuel F. Mullins of Danbury. The new Councilors are welcomed around the

(*Continued on Page 432*)

Our Neighbors

NEW JERSEY

The Medical Society of New Jersey may well be proud of the fact that its records have been preserved intact during its 174 years of continuous existence. These records include the names of those who attended the meetings and the public projects to which they gave their time and efforts with no mention of the benefits which might accrue to themselves. The Society was founded on July 23, 1766.

* * * *

NEW YORK

Believing that medical welfare is the most important problem facing the medical profession today and that at the present time it is in a chaotic condition throughout the State, the House of Delegates of the Medical Society of the State of New York at its recent annual session created a subcommittee of three members of the Council charged with the sole duty of considering problems of "medical relief." It is the opinion of physicians in New York State that medical relief is different from all other relief services and must be recognized as a separate and distinct category of welfare activity and therefore administered as such. They are anticipating real results from this subcommittee.

* * * *

RHODE ISLAND

The June issue of The Rhode Island Medical Journal carries an outline of "Tentative Plans for a New England Academy of Medicine." These plans are postulated on the ground that there is an urgent need of better postgraduate facilities and that "everybody agrees that postgraduate education should be more universal." The purpose of this Academy as stated is: "To foster interest in and provide for continued postgraduate education among the medical profession for all time by whatever means is best suited to meet individual and group needs." There are active individual members, associate individual members, institutional members, associate institutional members and honorary members. Its functions are related entirely to promoting present as well as contemplated postgraduate medical facilities and it is planned to have a central executive headquarters in Boston with operating units in each state.

- NEWS -
from County Associations

Hartford

Doctor Albert J. Robinson, medical director of the Connecticut General Life Insurance Company, was elected chairman of the Medical Section of the American Life Association at its recent session held at Colorado Springs. Doctor Robinson has also been appointed by the Council of the State Medical Society to the Committee to Study the Statutes Regulating the Offices of the County Coroners.

In the April issue of the Journal of the Indiana State Medical Association was published a paper on "The Physician in the Schools" by Doctor Charles C. Wilson, director of Physical and Health Education, Board of Education, Hartford.

At the last local meeting of the Hartford Medical Society, papers on Gastric Hemorrhage were read. Doctors John Wentworth and Lawrence Cogswell discussed gastric hemorrhage from a medical viewpoint and Doctor Richard E. Dunne read a paper dealing with the surgical aspects of gastric hemorrhage. Many important facts and features in regard to this problem were given by the men whose very able presentations were well received by the members present.

Doctor Dillon Reidy is convalescing at St. Francis Hospital after a recent operation.

Doctor Andrew F. Resnisky has returned to his home following an operation on May 21, at St. Francis Hospital.

The attention of the members is called to the formation of a Compensation Committee recently named at the annual meeting of the Connecticut State Medical Society. This Committee has members representative of all counties and congressional districts of the state and it is earnestly hoped that this Committee will be consulted by members of the Society whenever they may see fit to do so.

A very enjoyable reunion was held on May 21, 1940, by the Interne Alumni and Staff Association of St. Francis Hospital. After visiting at the Hospital and renewing old acquaintances, a banquet was held in the evening at the Wampanoag Country Club. There were about 130 members present and an enjoyable time was reported to have been had by all.

* * * *

Middlesex

Following examination, F. Erwin Tracy has been made a diplomat of the American Board of Internal Medicine. Doctor Tracy is also a Fellow of the American College of Physicians.

On the evening of Monday, May 20, Doctor Robert J. Lawton of Waterbury addressed the Central Medical Association of Middletown on "The Diagnosis and Treatment of Skin Diseases." Doctor Lawton's paper was very much appreciated by the many members of the society in attendance.

* * * *

New Haven

Doctor John R. Paul of New Haven addressed the Philadelphia County Medical Society on May 8. His subject was "Recent Developments in the Epidemiology of Poliomyelitis."

Doctor Clyde L. Deming of New Haven discussed a paper on "Hydronephrosis" by Doctor Thomas E. Gibson at the recent meeting of the New England Branch of the American Urological Association.

☆☆

AMERICAN COLLEGE OF SURGEONS PUBLISHES MANUAL OF GRADUATE TRAINING IN SURGERY

Pursuant to its aim of raising the standards of surgery, the American College of Surgeons has published a 24-page "Manual of Graduate Training in Surgery" in which are incorporated the requirements for its approval of programs of training in general surgery and the surgical specialties in hospitals of the United States and Canada.

The "Manual" is the outcome of ten years of study of educational programs in surgery by the Board of Regents and several committees of the College. In 1937, a Committee on Graduate Training in Surgery was established under whose direction the field staff of the College personally surveyed a selected group of hospitals in connection with the work of the Hospital Standardi-

(Continued on Page 430)

Letters to the Editor

June 13, 1940

Dr. Stanley B. Weld, Editor
Journal of Connecticut State Medical Society
179 Allyn Street
Hartford, Connecticut

Dear Doctor Weld: —

The attention of the members of the Connecticut State Medical Society is earnestly directed to a knowledge of the fact that a Compensation Committee with state-wide representation was named at the recent annual meeting of the Connecticut State Medical Society. Several years ago there was a committee which was quite active and which amassed a tremendous amount of data in regard to the working of the Compensation Law, not only in the state of Connecticut but in other states. This committee which was simply a fact-finding body found considerable in the way of problems and abuses which concerned not only the profession itself but also the insurance carriers and labor. Because of the assembling of these facts and the manner in which they were assembled, that is, by meeting with representatives of the insurance companies, labor and of the medical profession, many abuses were removed, many conditions were bettered, and many problems were solved. But during recent years, although committees of the various counties have been named, there has been little or no activity and this absence of action has been the greatest complaint of all on the part of some members of the profession.

The new committee whose names are listed below desires to be of service to the Medical Society and to the medical profession at large insofar as it is able. Therefore, we wish the existence of this committee to be publicized among the members of the Society and for the members to realize that there is a body with whom they may register complaints and to whom they may present problems. Lest it seem that the function of the committee be one-sided, that is, only looking out for the interest of the profession, it is urged that whenever situations have occurred which merit the praise of any concern in relation to the working of the compensation that the committee be appraised of these things also.

For example, only recently one of the members of the committee had occasion to witness quite a benevolent act on the part of one of the insurance carriers in this state. Contrariwise, while a formal complaint has not yet been made and, therefore, no particular stress to be laid upon it at this time, it has been alleged by one of the members of the Society that one of the Compensation Commissioners was instrumental in directing a patient away from him and another physician to one of their colleagues.

Again we ask each and every one who reads this letter to inform other members of the Society of the existence of this committee. From the names listed below you will find the man who represents your district or county and you are asked to present any matter you wish to have acted upon to him. Herewith are the members of the Compensation Committee:

Benedict B. Landry, Chairman
50 Farmington Avenue, Hartford
George W. Dunn
55 West Main Street, New Britain
Charles Kaufman
308 State Street, New London
Benjamin A. Roccapriore
504 Main Street, Middletown
Frederick W. Roberts
129 Whitney Avenue, New Haven
James D. McGaughey
261 Center Street, Wallingford
D. Chester Brown
330 Main Street, Danbury
J. Leonard Vickers
31 Hillside Drive, Greenwich
Edward H. Kirschbaum
20 Grove Street, Waterbury
Thomas J. Danaher
82 Litchfield Street, Torrington

Very truly yours,

Benedict B. Landry, M.D.

WHAT THE OTHERS THINK OF US

American Medical Association
Chicago, Illinois
May 11, 1940

To the Editor:—

A copy of the Convention Number of the Connecticut State Medical Journal has just come to my desk. I am leaving almost at once to attend the annual meeting of the State Medical Association of Texas at Dallas, but before going I am taking the time to send you a word of congratulation and commendation on this splendid number of the Connecticut State Medical Journal.

With most cordial good wishes, I am

Very sincerely yours,
Olin West

* * * *

Cooperative Medical Advertising Bureau,
Chicago, Illinois
May 11, 1940

To the Editor:—

Congratulations on your May issue. It is the best job I have ever seen in securing local advertising. I am very curious to know just how you went about getting this business, because I should like to pass the information on to our other publishers.

Very best wishes.

Cordially yours,
H. L. Sandberg, Director

* *

To the Editor:

The American Social Hygiene Association is interested in getting the following information to the medical profession and asks your cooperation in publishing this statement:

In order that there may be a central source of information with regard to studies of the intravenous drip method of treatment of syphilis ("the five day treatment"), the American Social Hygiene Association at 50 West 50th Street, New York, has been asked to gather and to keep available information regarding this subject. The Association requests all physicians and

The PROFESSIONAL EQUIPMENT Co. EQUIPMENT and SUPPLIES for PHYSICIANS, SURGEONS and HOSPITALS TEL. 7-2138 NEW HAVEN, CONN.

(SEE PAGE 2.)

hospitals which are planning or are now carrying on studies of experiments with this method of treatment of syphilis to send brief information regarding the following points to the Association at the above address:

1. Name of hospital or other institution.
2. Name of principal physician in charge of the intravenous drip study.
3. Type of case or cases of syphilis treated by the intravenous drip method.
4. Name of drug or drugs used.
   (a) By the intravenous drip method
   (b) By any other method before, during or after intravenous drip therapy. (Mention any specific therapy used.)
5. Routine laboratory work done on cases of syphilis treated by the intravenous drip method.
6. Usual number of hours of intravenous drip treatment per day per patient.
7. Usual number of days of intravenous drip treatment per patient.
8. Any other pertinent facts.

The Association will be glad, so far as possible, to answer inquiries regarding the intravenous drip treatment of syphilis. The Association has available to physicians, upon request, a brief pamphlet on the subject of the present status of the intravenous drip method of treatment of syphilis, written by Dr. Charles Walter Clarke, Executive Director of the Association and a member of the New York City Committee on the Intravenous Drip Treatment of Syphilis.

The American Social Hygiene Association
50 West 50th Street
New York, N.Y.

⁂

To the Editor:—

The Medical Association of the State of Alabama begs to call to your attention the following important resolution adopted by it on April 18, 1940:

A Resolution

Introduced by Dr. M. Y. Dabney of Birmingham

Whereas, There is a growing tendency to patent drugs in the name of universities and foundations in connection with universities; and

Whereas, These patents are presented to the institutions by the discoverers; and

Whereas, The discoverers of the products are usually medical men; and

Whereas, The effect of the patents is to increase the price of the drugs because of the royalties imposed by the said foundations; and

Whereas, A considerable proportion of patients in need of the new products are prevented from buying them by reason of the necessarily high prices asked; and

Whereas, This hardship is imposed upon the needy public through the acts of the discoverers under the guise of foundations:

Be it Resolved, That The Medical Association of the State of Alabama condemns as unethical the patenting of drugs or medical appliances for profit whether the patent be held by a physician or be transferred by him to some university or medical research foundation, since the result is the same, namely, the deprivation of the needy sick of the benefits of many new medical discoveries through the acts of medical men; and

Be it further Resolved, That copies of these resolutions be sent to the leading medical associations and journals, to the leading medical colleges of the United States and Canada, and to the secretaries of all state medical associations as well as to that of the District of Columbia.

Montgomery Douglas L. Cannon, M.D.
May 15, 1940 Secretary

⁂

AMERICAN COLLEGE OF SURGEONS

(*Continued from Page 428*)

zation Department. Based on the findings of these surveys, "Fundamental Principles and Criteria" were developed which have been applied in evaluation of plans for graduate training in surgery. The plans of 179 hospitals have so far been approved by the College. The new "Manual" is an elaboration of the "Fundamental Principles and Criteria" and will in the future be applied in determining eligibility for the Approved List to be published in the Approval Number of the College BULLETIN in October of each year.

(*Continued on Page 435*)

The PROFESSIONAL EQUIPMENT Co. X-RAY SUPPLY and SERVICE SPECIALISTS. KELEKET APPARATUS. TEL. 7-2138 NEW HAVEN, CONN.
(SEE PAGE 2.)

SPECIAL NOTICES

NEW ENGLAND PEDIATRIC SOCIETY

The attention of the officers of the New England Pediatric Society has been called to the fact that it is believed generally that membership in the society is limited to pediatricians. This impression is entirely erroneous. The New England Pediatric Society is an organization devoted to the dissemination of a better understanding of the problems of infancy and childhood and its membership includes many practitioners other than pediatricians. Its purpose can be accomplished only by enlarging the membership to include a greater number of physicians in new England who are interested in the care of infants and children. Any qualified physician who has such an interest is eligible for membership and will be welcomed into the society.

The society has previously held three or four meetings each year, usually in Boston, of clinical and scientific nature. It is planned that additional meetings be fostered in various parts of New England in order that those members unable to attend in Boston can keep informed of progress in this field of medicine. These would consist of round table discussions or clinical demonstrations rather than didactic lectures. Such meetings would necessarily be at the instigation of the local or county medical groups and would be under the direction of someone provided by the New England Pediatric Society.

Inquiries should be addressed to the secretary.

1101 Beacon Street, Brookline, Mass.
JAMES MARVIN BATY, M.D., *Secretary*
R. CANNON ELEY, M.D., *President*

* * * *

EXAMINATIONS
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 4, 1941, at 2:00 P.M. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 5, 1940.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, immediately prior to the 1941 meeting of the American Medical Association.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, (6) Pennsylvania.

TENTH MEETING OF THE BIOLOGICAL PHOTOGRAPHIC ASSOCIATION

The tenth annual convention of the Biological Photographic Association will be held at the Hotel Schroeder, Milwaukee, Wisconsin, September 12, 13 and 14. This society is interested in the further study of photography as applied to the biologic sciences, and the improvement of its technic. Scientific photographers from all parts of the country will meet to exchange ideas and information on still and motion picture photography as well as the latest developments in color work. Formal papers will be presented outlining new methods of technic, and there will be informal round-table discussions which will be especially instructive. Commercial firms specializing in the manufacture of scientific photographic apparatus and materials will exhibit and explain the use of their products. A salon consisting of natural color and monochrome prints of biologic and clinical subjects will illustrate a very fine degree of perfection in biologic photography.

During the past year the B.P.A. has offered its cooperation to the United States War Department in connection with a plan to organize clinical illustration units in the medical division in time of war. A questionnaire formulated by the War Department has already been distributed and a complete discussion will be in order at the September meeting.

The membership of the Biological Photographic Association is composed of professional clinical and biologic photographers as well as physicians, dentists and scientists who are interested in this specialized branch of photography. A quarterly journal is published containing articles of vital interest to the biologic photographer. The society also circulates albums dealing with specialized photographic technics and travelling salons for exhibition purposes. These travelling salons are made up of selected prints from the annual meetings and make excellent exhibit material for various scientific conventions. At the end of a year the prints are returned on request to exhibitors.

In view of the growing interest in medical and biologic photography the next annual meeting promises to be especially stimulating and successful. Anyone interested in this subject is welcome to attend the meetings and to submit prints for the salon.

Further information concerning the convention program, salon specifications and membership in the society may be had by writing to the Secretary of the Biological Photographic Association, University Office, Magee Hospital, Pittsburgh, Pa.

* * * *

1940 GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

The 1940 Graduate Fortnight of The New York Academy of Medicine will be held from October 14 to 25, 1940.

The subject of this year's Fortnight is INFECTIONS.

The purpose of the Fortnight is to make a complete study and authoritative presentation of a subject of outstanding importance in the practice of medicine and surgery.

The Fortnight will present a carefully integrated program which will include morning panel discussions, afternoon clinics and clinical demonstrations at many of the hospitals of New York City, evening addresses, and appropriate exhibits. The evening sessions at the Academy will be addressed by recognized authorities in their special fields, drawn from leading medical centers of the United States. The comprehensive exhibit will include books and roentgenograms; pathological and research material; and clinical and laboratory diagnostic and therapeutic methods. It is also planned to provide demonstrations of exhibits.

The subject of the Fortnight will include the following:

Experimental basis of chemotherapy in the treatment of bacterial infections
Clinical bacterial chemotherapy, results obtained and dangers encountered
A general consideration of bacterial infections
Recent advances in knowledge of streptococcal infections
Infections of mouth, pharynx and upper respiratory tract
Infections of middle ear and nasal sinuses
Infections of teeth and surrounding structures
Influenza
Pneumococcal infections
Bacterial meningitis
Infections of the urinary tract
Gonococcal infections in the male
Gonococcal infections in the female
Osteomyelitis and pyogenic infections of joints
Wound infections
Puerperal infections
Treatment of infections by methods other than chemotherapy
Virus infections
Acute poliomyelitis
Brucellosis — undulant fever
Rickettsial diseases
Lymphogranuloma venereum
Epidemic encephalitis
Other forms of encephalitis and choriomeningitis
Exanthematous diseases

The Academy provides this program for the fundamental purpose of medical education, consequently all members of the medical profession are eligible for registration.

A COMPLETE PROGRAM AND REGISTRATION BLANK MAY BE SECURED BY ADDRESSING:

Dr. Mahlon Ashford, The New York Academy of Medicine, 2 East 103 Street, New York City.

MICHAEL REESE HOSPITAL
CARDIOVASCULAR DEPARTMENT
Offers a Full-time Intensive Course
in
ELECTROCARDIOGRAPHY
Two Weeks—August 19—August 31, 1940
by Dr. Louis N. Katz

Director of Cardiovascular Research

This is an intensive course offered to the general practitioner. There will be practice on several electrocardiographic machines and discussion of the principles of their construction and use. There will be sessions on interpretations of electrocardiograms illustrated by lantern slides, and practice by the student with unknown records. Routine records taken during the time of the course will be discussed. Emphasis will be placed on chest leads and on the importance of the electrocardiograms in coronary sclerosis and myocardial infarction. The mechanism and interpretation of heart irregularities will be developed.

As group and individual instruction will be given, the course is open to both the beginning and advanced student in Electrocardiography. It is planned to individualize the course so that at the end of the period each student will be capable of taking and properly interpreting routine electrocardiograms. In order to accomplish this purpose the class will be limited in number. It is imperative, therefore, that reservations be made early.

Reservations may be made upon receipt of $10.00 which will be applied on the tuition. An hourly program of the course will be sent on request.

For further information address:

MICHAEL REESE HOSPITAL
CARDIOVASCULAR DEPARTMENT
29th and Ellis Ave.
Chicago, Illinois

* * * *

ANNUAL REPORTS

(*Continued from Page 426*)

big table where your affairs are so carefully looked after, but I must warn them that membership in the Council is no longer the quiescent honor that it was a few years ago. There is work ahead for them and I know they will meet it willingly.

As we look into the future there are uncertainties on every hand but that uncertainty does not apply to this Society. Our course and purposes are clear. Your new President will bring to you fine judgment and guidance and the organization is prepared for whatever may come.

Respectfully submitted
J. D. GOLD

The PROFESSIONAL EQUIPMENT Co.
RENTAL SERVICE
on WHEEL CHAIRS, SUN LAMPS, HOSPITAL BEDS, OXYGEN APPARATUS, etc.
TEL. 7-2138
NEW HAVEN, CONN.

(SEE PAGE 2.)

• OBITUARIES •

FRANK WILLIAM HEWES, M.D.

1867-1939

Doctor Frank William Hewes of Groton, died on August 18, 1939, at the age of 72. Doctor Hewes was born in South Stratford, Vt., April 14, 1867, the son of Freeman Stark and Roxana Carr Hewes who represented prominent old families of their community. He prepared for college at Thetford Academy, Thetford, Vt., and at Goddard Seminary, Barre, Vt., then he attended the University of Vermont graduating in turn from the academic and medical departments. While there he was much interested in athletics and played base ball. He preserved a lively interest in the game for many years.

After Doctor Hewes had received his M.D. he took a postgraduate course at the New York Post-Graduate School and Hospital, then after an internship and a year of practice in New York City he located in Groton in 1895. For forty four years he practiced there with commendable success. For twenty-five years he was health officer of the borough of Groton and for many years medical examiner for the town of Groton.

Doctor Hewes was a lover of the field and stream and habitually spent several weeks each spring and fall at his summer home in Vermont. He was president of the Connecticut Fish and Game Commission from 1911-1913. He was a member of Shennecossett Yacht and Tennis Club and of the Groton's Sportsmen's Club. He was a member of the Masons, Knights Templar and the Odd Fellows. Doctor Hewes preserved an erect figure of unusual height and carried many youthful traits into his later years. He was a pleasing conversationalist and excelled in droll stories and practical jokes. His friendships were many.

Doctor Hewes married Nettie Ludwig who died in October, 1938, He is survived by two sons, Frank W. Hewes, Jr. and C. Tyson Hewes, M.D., both of Groton, also by five grandchildren.

Charles D. Barnum, M.D.

• Quarto Notes •

THE ESTIMATION OF PELVIC CAPACITY

by

Herbert Thoms, M.D., Associate Professor of Obstetrics and Gynecology, The School of Medicine, Yale University

46 pages

New York The American Journal of Surgery 1940

It is a source of extreme satisfaction as well as of pride to have the privilege of offering a review of such a valuable monograph as this one, written by a member of our Society. Doctor Thoms' contributions in the field of obstetrical pelvimetry have been outstanding during the past twenty years. His attention to important details and his success in perfecting a satisfactory method of pelvimetric Roentgen technic, coupled with a grasp of the entire problem unsurpassed by any obstetrician to date, serve to enhance the value of his findings and lend weight to his conclusions.

This monograph is handsomely bound and affords the reader a large number of cuts, charts and tables which add to the clarity of the presentation. The bony pelvis, the significant pelvic diameters, pelvic variations, and the estimation of the pelvic capacity are all discussed. In addition the technic of Roentgen methods for pelvimetry is outlined. Finally, lest the reader become over enthusiastic with the modern methods of diagnosis, he is reminded by the author that "the greatly useful knowledge which the Roentgen methods has given us must be properly assimilated with our greatest therapeutic weapon, namely, clinical experience."

* * * *

THE NEWER NUTRITION in PEDIATRIC PRACTICE

Edited by

I. Newton Kugelmass, B.S., M.A., M.D., Ph.D., Sc.D. Attending Pediatrician, Broad Street Hospital and Heckscher Institute, N.Y.

1155 pages $10.00

New York J. B. Lippincott Company 1940

This unusual work, which is really an encyclopedia of physiology and nutrition, both normal and pathological, might well be in the library of every pediatrician. The subjects it covers are very lucidly and interestingly presented and the bibliography which accompanies each section is most comprehensive.

The volume is divided roughly into three units. The first deals with normal physiological processes together with a consideration of the nature and behavior of nutrient substances. The second unit deals with nutrition in health and constitutes a practical treatise on the growth and feeding of children. Section three considers nutrition in disease and contains an excellent discussion of the etiology, diagnosis and treatment of the deficiency, metabolic and allergic diseases.

This volume of Dr. Kugelmass' is primarily a book for reference purposes but offers most interesting and comprehensive reading, especially in the science of the newer aspects of nutrition.

In most such pretentious volumes one occasionally runs across matter which is somewhat obsolete but it was rather a shock to find in this book full page illustrations showing the technique of intraperitoneal injections of saline and emergency transfusion of blood into the longitudinal sinus.

On the whole, however, this is an excellent book.

H. W. Brayton

MINOR SURGERY

by

Frederick Christopher, S.B., M.D., F.A.C.S.
Associate Professor of Surgery, Northwestern University Medical School

990 pages 639 illustrations (Fourth edition) $10.00
Philadelphia W. B. Saunders Co. 1940

That a fourth edition of this book has appeared since the first edition in 1929 is a tribute to the deserved popularity of this book. The entire volume has been thoroughly revised and the results of recent studies incorporated to present many new and useful methods.

The organization and excellent presentation of former editions has been preserved. The first seven chapters cover general topics with the next fifteen chapters devoted to regional minor surgery with particular reference to injuries, infections, and tumors and deformities. The last two chapters on minor surgical technique and the surgical interne are of particular value.

The author recognizes the recent criticism of the term Minor Surgery as expressed editorially in "Surgery" by Royster under the title "Minor Surgery is Taboo" but can find no better term as title for his book. In general the recognition that many of the subjects covered often have major surgical implications is adequate.

One of the notable deletions is the technique of the injection treatment of hernia. In explanation the author concludes:—"Despite its enthusiastic advocates, this type of treatment can no longer be recommended; hence, the description is omitted here."

Criticisms of this text can be few and only of a minor nature. The discussion of tumors does not have the same excellence as coverage given the injuries and infections. For example, it seems undesirable to include the statement attributed to Evans and Leucutia on page 263 that, "They consider excision of a pigmented mole a very dangerous procedure and treat all pigmented moles and melanomas by x-ray." Even though subsequently the author quotes Lee in larger type to the effect that, "The only way to achieve better results is to urge physicians to recommend prophylactic excision of all pigmented areas that are exposed to trauma or irritation."

The volume has become such a standard reference to the general practitioner, surgeon, and interne that recommendation of this text is unnecessary. It certainly should be a "must" for the surgical interne and house officer.

P. G. McLellan

DIABETES

by

Edward L. Bortz, A.B., M.D., F.A.C.P.,
Associate Professor of Medicine, Graduate School of Medicine, University of Penn.

290 pages $2.50
Philadelphia F. A. Davis & Co. 1940

This second edition is brought up to date and expanded from 217 to 290 pages. The general outline of the book emphasizes the normal and the way the diabetic can be returned to and maintained at that normal. The chapters on food facts, body energy, and hygiene in the diabetic section of the book, and those by Sister Maude Behrman on diet survey, diet calculation, and food values could well be in any good book on dietetics. The chapters connecting the normal to the diabetic are well placed and clearly written.

Several subordinate sections are contributed by others as a good chapter on diabetes in children by Dr. Walter M. Bortz, dental care by Dr. C. F. Hellwege, care of the feet by Dr. J. M. Deaver. These chapters are as complete as a lay text should be but do not quite carry the interest of the main sections of the book.

At the end of each chapter have been added "helpful questions" to summarize its content to the diabetic using this text. The glossary at the beginning of the book explains many medical words for the uninitiated. The appendix has excellent tables giving household measures as well as weights for measuring foods, and giving values in terms of vitamines and minerals as well as carbohydrates, protein and fat. Also included is a table, not usually found, of alcoholic beverages.

This book summarizes to date the knowledge of diabetes and presents measures for maintaining the health of the diabetic. It also sets up excellent standards of normal to serve as guides. Its general outlook is hopeful and constructive. It adds another good diabetic manual more complete than usual.

B. J. Buck

* * * *

HANDBOOK OF ORTHOPAEDIC SURGERY

by

Alfred Reeves Shands, Jr., B.A., M.D.
Medical Director, Nemours Foundation, Wilmington, Delaware

567 pages $4.25
St. Louis C. V, Mosby Co. 1940

As its name implies, this is a real handbook of orthopaedic surgery. Its 477 pages are filled with meat and very well illustrated with only the essential pictures necessary. It contains a splendid bibliography, which is divided into chapters and topics identical with those of the text. This is a most convenient arrangement and the authorities are well selected. The 24 page index is adequate, the type is large, and the style easy to read. It is just the book to furnish a quick review of the entire subject of orthopaedic surgery for the busy specialist.

R. M. Yergason

DOCTORS IN SHIRT SLEEVES

Edited by
Sir Henry Bashford

294 pages $2.50
New York Veritas Press 1940

This volume is a collection of essays, off duty musings as it were, of twenty English physicians originally appearing in the Lancet under the heading of 'Grains and Scruples'. Some are interesting, some are boring, but from their very nature what appeals to one reader might be of little interest to the next.

There is some very good philosophy found within the pages of this English volume; for example, in the chapter on "Crabbed Age and Youth," where the author, in bemoaning the passing of the college "beefing" groups now replaced by attendance at the cinema, says "this education of one another by ourselves was surely one of the most valuable things in university life." Again, how vivid and homely the sketches drawn for the reader in "West Country Patients?" "Medical Students, Old and New" might well apply to America for certainly it is just as true in this country that "there is no better student than the son of a medical father if the boy's heart is in the work, but none is worse than he who, not caring for, or even disliking, is urged on by a medical parent to qualify in order to take his place." "Some Thoughts on Meals" reminds one in its title only of "The Autocrat of the Breakfast Table" but the content is more culinary.

The book improves as it nears the end. "The Biology of War," "Medicine and Philosophy," "Some Old Days in India," and "Retirement and a Garden" are worth reading. From the first of these chapters comes this: "I do not believe there is any right or wrong in war. The phenomenon is as devoid of ethics as typhoid, but equally unpleasant, so let us consider it as a social disease and the subject of an unwritten chapter in some text book of medicine." And again: "Who will win the next war? Probably the strongest industrial community or group of such communities. *But revolution may come first.*" And at the end comes retirement and a garden. "It is far more fun to make a garden, where no garden was before, than to become the possessor of a spick-and-span one made by some one else."

The reader will close the book, poke the logs in the fireplace and put out the light, glad that there is something more in life than the routine of pills, powders and patients.

☆☆

AMERICAN COLLEGE OF SURGEONS

(*Continued from Page 430*)

The College recognizes three principal types of institutions as offering acceptable programs of graduate training in surgery: (1) universities or teaching hospitals supervised by departments of surgery of medical schools and graduate schools; (2) fellowships in recognized clinics and other organized groups; and (3) selected hospitals which by utilizing their own facilities to the fullest are able to carry acceptable programs through to completion, or which have supple-

(*Concluded on Page 436*)

Prescribed for the Professional Palate

There's no whisky to please your palate more completely than Johnnie Walker. For there's no finer whisky than Scotch, and Johnnie Walker is Scotch at its smooth, mellow best.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820
... still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE
Wyeth

HAS SHOWN A CONVINCING RECORD* OF EFFECTIVENESS IN ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae • Trichomonas vaginalis
Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

AMERICAN COLLEGE OF SURGEONS

(*Continued from Page 435*)

mented their educational program, particularly in the basic medical sciences, through affiliation with medical schools and graduate schools.

The Minimum Standard for Graduate Training in Surgery, which is included in the new "Manual" comprises five clauses, concerned with (1) duration and objective of the program; (2) organization and supervision; (3) basic medical sciences) (4) clinical material and (5) organized study.

Under the requirements, an acceptable program requires a minimum of two and preferably three or more years of training in surgery, beyond at least one year of general internship. Such preparation is now necessary in order for an applicant for fellowship in the American College of Surgeons to meet the qualifications in respect to training, as set forth in the following resolutions passed by the Board of Regents on May 10, 1936:

"Applicants for fellowship whose qualifying medical degree shall have been obtained after the date of January 1, 1938, shall be required to present evidence of having completed three years of hospital service in one or more acceptable hospitals, of which two years shall have been spent in training in surgery in hospitals approved by the American College of Surgeons. In the case of graduates of medical schools which withhold the medical degree until after the fifth year of hospital internship, the date set will be January 1, 1939."

Dr. Dallas B. Phemister, Chairman of the Department of Surgery, University of Chicago School of Medicine, is chairman of the Committee on Graduate Training in Surgery; the other members are D. Donald C. Balfour of Rochester, Minnesota; Dr. John R. Fraser of Montreal; Dr. Albert C. Furstenberg of Ann Arbor; Dr. W. Edward Gallic of Toronto; Dr. Harry S. Gradle of Chicago; Dr. Evarts A. Graham of St. Louis; Dr. Howard C. Naffziger of San Francisco; Dr. Gilbert J. Thomas of Minneapolis; and Dr. Allen O. Whipple and Dr. Philip D. Wilson of New York City. Much of the field work and direction of the study has been carried on by Dr. Harold Earnheart, assistant director of the College, in collaboration with Associate Directors Bowman C. Cromwell and Malcolm T. MacEachern.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1940-1941) . . . 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) . . . 5

ORIGINAL PAPERS:

Allergy in General Practice . . . Jesse S. Harris, M.D., New Haven, Conn. 437

The Connecticut Way . . . Joseph I. Linde, M.D., New Haven, Conn. 443

That Secondary Adenoid and Tonsil Operation — William H. Turnley, M.D., Stamford, Conn. 447

Unusual Case of Pancreatic Abscess . . . Peter J. Steincrohn, M.D., Hartford, Conn. 450

ABSTRACT:

Relation of Pain Relieving Drugs to Respiratory Morbidity — Ralph M. Waters, M.D., Madison, Wisconsin 453

Association of Connecticut Tumor Clinics — Seventeenth Meeting of the Association, New Haven, May 2, 1940 454

STATE DEPARTMENT OF HEALTH:

The Periodic Health Examination — Matthew H. Griswold, M.D., Dr. P.H., Hartford, Conn. 471

EDITORIALS:

A Plea For Conservatism . . . 475

Connecticut and the Nation's Defense . . . 477

The Graduate Medical Student's Problem . . . 477

Our Greetings to Two New Journals . . . 478

FROM THE SECRETARY'S OFFICE . . . 480

LETTERS TO THE EDITOR . . . 481

CONNECTICUT HOSPITAL ASSOCIATION . . . 482

GENERAL PRACTITIONER'S FORUM . . . 485

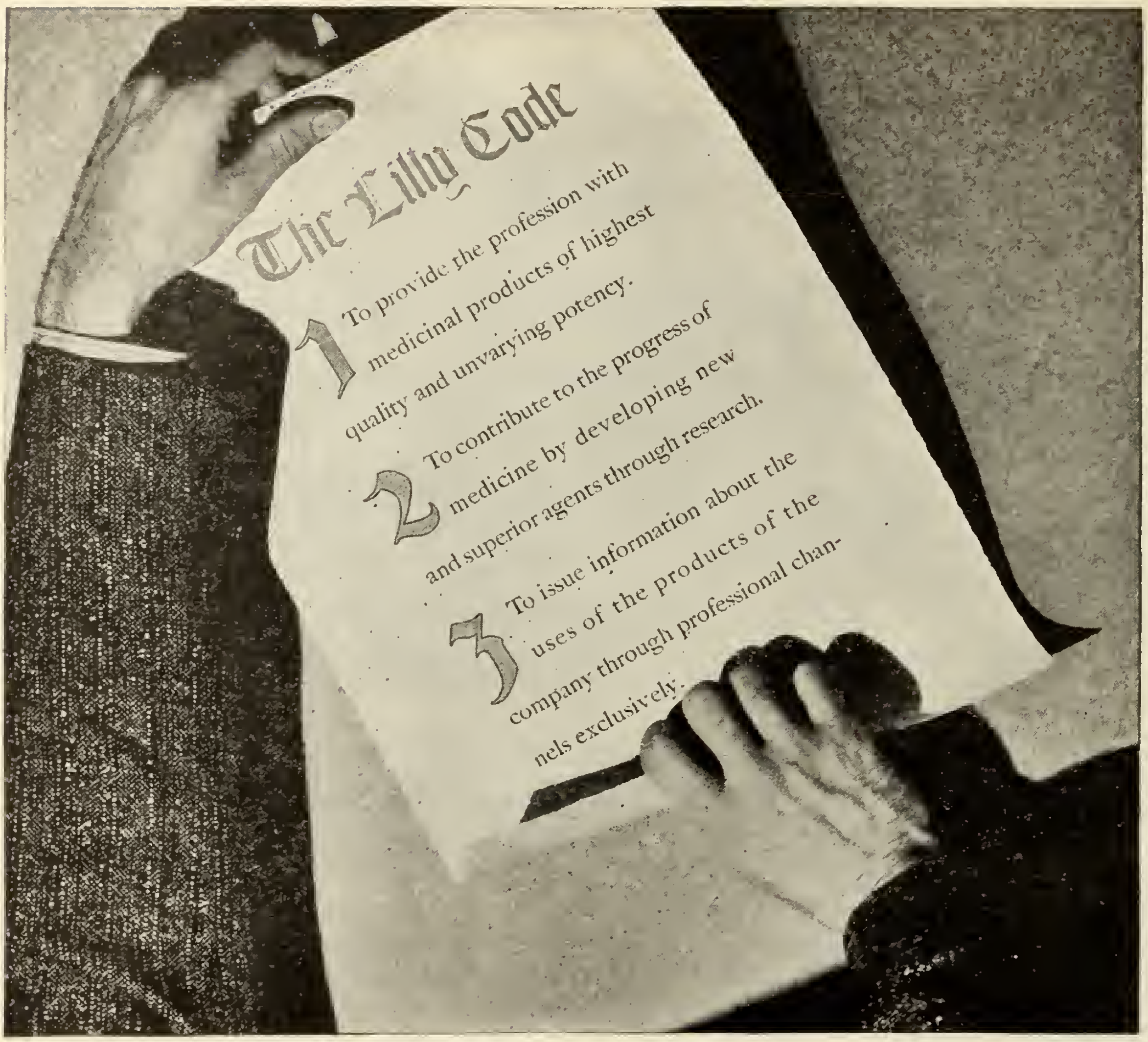
OUR NEIGHBORS . . . 486

NEWS FROM COUNTY ASSOCIATIONS . . . 487

SPECIAL NOTICES . . . 489

QUARTO NOTES (Book Reviews) . . . 490

CHARTER AND BY-LAWS, CONNECTICUT STATE MEDICAL SOCIETY . . . 492



The Lilly Code

1 To provide the profession with medicinal products of highest quality and unvarying potency.

2 To contribute to the progress of medicine by developing new and superior agents through research.

3 To issue information about the uses of the products of the company through professional channels exclusively.

Dependable Antiseptic

'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly), germicide of many uses, is noted for its general applicability to all types of clinical antisepsis and for its compatibility with body tissues. In addition to Tincture 'Merthiolate' and Solution 'Merthiolate' the antiseptic is available in special preparations of jelly, cream, ointment, and suppositories.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

These are your Friends

The Connecticut State Medical Journal

Vol. IV. AUGUST, 1940 No. 8

Allergy in General Practice

JESSE S. HARRIS, M.D.
New Haven, Conn.

In the past two decades we have become increasingly aware of the great importance of the subject of Allergy to every physician engaged in the general practice of medicine and surgery. Its symptoms may occur in every part of the body. Primarily a functional phenomenon and only secondarily organic, it may simulate any other specific illness, and frequently colors the picture of the latter disease. The patient may suffer from hay fever or hyperesthetic rhinitis, iritis or vernal conjunctivitis, eczema, urticaria, or asthma. Numerous instances of gastro-intestinal allergy are seen, and no office is without its migraine sufferers. He may come because of joint pain and it is frequently difficult for the surgeon to differentiate between certain types of abdominal pain as allergic manifestations rather than surgical disease. When not to operate in the asthmatic, his tendency to postoperative pulmonary atalectasis and the choice of anesthetic, are important problems for the surgeon. How very frequently the obstetrician is concerned about the effect of asthma in pregnancy and allergic disease in general in the new-born! Bladder pain, hematuria, and frequency may be functional evidences of underlying sensitivities, and it is for these many reasons that it behooves the general practitioner to acquaint himself with the more common facts of allergy.

May I mention briefly some of the common terminology frequently encountered in the literature.

Allergy may be defined as a changed or altered reaction; a natural hypersensitivity with an abnormal or excessive response in any portion of the body to chemical or physical stimuli, which do not similarly affect the greater proportion of people. The very same stimilus given in similar amounts to the non-allergic individual proves utterly harmless.

Sensitivity or hypersensitivity are general terms which include both natural clinical allergy and 'artificial' animal anaphylaxis. They refer to that condition or state in an individual who has a very definite and characteristic symptom-complex from contact with otherwise harmless substances. A small amount of egg which has no ill effect on 90% of us may, in the sensitive or hypersensitive person, cause rhinitis, asthma, eczema, hives, or gastro-intestinal symptoms.

Anaphylaxis, meaning 'without protection', is an artificially produced symptom-complex due to an antigen antibody reaction. Repeated injections of a serum, instead of producing an immunity against these substances may produce rather an increased susceptibility. A second injection of serum after a suitable delay, one to two weeks, may be harmful and even fatal instead of being protective and prophylactic. Thus, to contrast it with a protective or prophylactic state, the term anaphylaxis or 'without protection' is used.

This fortunately rarely occurs in the human being and may follow a second injection of either tetanus or diphtheria antitoxin. There are records of fatal reactions following even the initial injection of sera, usually in large amounts of undiluted solution. The use of toxoid, both tetanus and diphtheria, has decreased the occurrence of human anaphylactic reactions.

Atopy, which means 'strange disease', was a term coined by Coca to describe clinical forms of hypersensitivity or allergy which occur only in human beings and are not seen in lower animals. To this group belong hay fever, asthma, certain types of eczema and both drug and food reactions. It implies that the hypersensitive or 'atopic' individual has something in his blood stream called 'reagins' which can be transferred to the skin of a normal individual. This fact has been used as the basis of the local passive transfer phenomenon.

The more common allergic symptom-complexes which confront the general practitioner may be subdivided as follows:

I. Serum Sickness — Serum Accidents or Anaphylactic Shock.
II. Upper Respiratory Allergy.
  A. Hay fever
    1. Seasonal type
    2. Perennial or all year type.
III. Lower Respiratory Allergy
  A. Bronchial Asthma.
IV. Alimentary Allergy
V. Skin Allergy
  A. Eczema
    1. Atopic allergic dermatitis
    2. Contact dermatitis
  B. Hives or Urticaria
  C. Angio-Neurotic Edema
VI. Migraine
VII. Drug Allergy
VIII. Physical Allergy
IX. Bacterial Allergy

I. Serum Sickness — Serum Accidents or Anaphylactic Shock.

Hypersensitiveness to animal serum has been well known for a long time. The most common and important is horse serum, although any animal sera may produce symptoms.

So called serum sickness occurs from three to ten days after the injection of the serum, and its most prominent symptoms are hives, angioneurotic edema, and exudation into the joints. Fever is frequently present when large doses of unconcentrated serum is used. It is due to the toxicity of the foreign serum and is in itself uncomfortable but not serious. The foreign serum continues to circulate in the blood stream as such until the onset of serum sickness, when evidence of antibody formation or 'precipitins' appear. At this stage the foreign serum as such disappears and the patient recovers from his serum sickness, but he has also probably become sensitized.

Serum accidents or anaphylaxis are fortunately much less frequent. They may occur in from a few moments to a few hours, either as generalized hives, sneezing, asthma, or even death. Horse serum, which is by far the most common cause, is commonly found in tetanus, diphtheria, and scarlet fever anti toxin, antimeningococcus and pneumococcus serum.

It is clearly impossible to prevent sensitization and serum sickness as long as we must use foreign serum. As noted above, the initial injection may produce discomfort, but is never serious. However, a severe serum reaction may become an added serious burden to any illness. Prophylactic injections of horse serum should be given only if necessary and, if possible a second or subsequent injection should be avoided within three months of the initial dosage. Concentrated purified serum is most preferable. The use of toxoid, which is the modified toxin without animal serum is rapidly gaining a well deserved favour. I cannot urge too strongly the routine necessity for care in the use of serum. If possible, the patient should be questioned for any history of allergic disease, family history, previous injections with horse serum, previous serum reactions, and particularly the duration of time since the last serum injection. Preliminary tests with diluted serum 1:100 should be done. Following a negative reaction, an initial injection of .02 of diluted serum should be given before the injection of the normal prophylactic dosage.

A word with regard to the control and treatment of reactions which do occur. A tourniquet or the injection of 0.3 cc. adrenalin chloride 1:1,000 above the site of injection will aid. Subsequent doses should be diluted 50%. In an emergency, good results are obtained by the slow intravenous infusion of 300 cc. of 10% glucose to which 1 cc. of adrenalin 1:1,000 has been added. In doubtful cases, one can frequently avoid trouble by the preliminary injection of 0.3 cc. of adrenalin before the serum is given, as adrenalin will not diminish its efficacy.

II. Upper Respiratory Allergy — Hay Fever.

1. Seasonal hay fever denotes a sterile inflammation of the membranes of the nose, eyes, and throat, due to specific sensitivity to the pollens. It is called allergic or vasomotor rhinitis and is to be differentiated from an infectious process involving the nasopharynx and conjunctive. The symptoms of sneezing, profuse watery discharge or nasal obstruction, itching of the nose, eyes and throat, are well known.

In general, the air borne pollens produce three hay fever seasons:

a. Spring: April 1st - June 1st. Due to tree pollens, chiefly oak, elm, birch, maple, hickory.

b. Summer: May 15th - July 15th. Due to grass pollens, chiefly timothy, red top, june grass, orchard grass, sweet-vernal, and english plantain.

c. Fall: Aug. 15th - Frost. Due to the ragweeds, cockleburr.

The diagnosis is made both by the history and specific tests with extracts of the various pollens. The conjunctival method is neither safe nor practical. Of the two cutaneous methods, the intradermal one, although slightly more dangerous, is far more accurate and preferable than the scratch method.

The treatment of hay fever should be both palliative and specific. There is no ragweed in the far north, in Bermuda or on the continent. To avoid trees and grasses is more difficult. Ephedrine and its synthetic products will help considerably. Specific treatment entails the increase of the individual's tolerance to pollen by the repeated injection in increasing doses of the responsible pollens. In the pre-seasonal method, we begin injections about ten weeks before the onset of the pollen season and attempt to reach the maximum dosage just prior to the onset of expected symptoms. Severe local swelling, and particularly any evidence of general reactions, such as sneezing, asthma, or hives, calls for caution. Patients should be watched for one half hour after treatment. Coseasonal treatment or rapid desensitization is less satisfactory and may be dangerous.

In the perennial method, which is much the best, treatment is similar to that in the preseasonal scheme, with maintenance doses continued monthly throughout the entire year. I have not had satisfactory results from the careful administration of pollen orally. Correct treatment will afford great relief to about 85% of the patients, and after a few years it is safe to discontinue injections for intervals of one to three years.

2. Perennial (all year) Hay fever. Vasomotor Rhinitis: Atopic Coryza

In this group the symptoms are essentially similar to those of seasonal hay fever, but are frequently accompanied by other allergies. Cold sensitivity may aggravate the symptoms in winter, while dust and seasonal foods cause summer exacerbations.

Usually the itching of the eyes and nose is less constant and less severe than in the seasonal type. The more important specific excitants are:

1. Those absorbed by Inhalation.
    a. Animal danders: horse, cat, dog, rabbitt, cow, chicken, goose, duck.
    b. Vegetable powders: orris root, corn, wheat, cottonseed, kapok, flax, hay and straw dust (not pollen)
    c. House dust.
    a. Foods: milk, egg, fish, shellfish, nuts, chocolate, coffee, pork, tomato.
    b. Drugs: aspirin, quinine, morphine, phenolphthalein.

Diagnosis should include both a general and special examination of the nose and sinuses. The nasal secretion is thin, clear, and contains many eosinophiles which are present even when secondary infection has occurred. Careful intradernal skin tests should be done.

Treatment is more diversified and comparable to that of asthma. Wherever possible, causative factors should be removed, but if this is not practical, subcutaneous injections of the specific offending agent should be given. The removal of nasal polypi and correction of a markedly deviated septum is indicated. Galvanocautery or chemical cautery of the turbinates may be of temporary benefit.

III. Lower Respiratory Allergy — Bronchial Asthma.

This distressing ailment is the most important allergic phenomenon, and is characterized by paroxysms of dyspnea, wheezing, and a productive cough. Coming on at first in long intervals, the attacks become more frequent, with symptoms persisting until finally the continuous orthopnoea, dyspnoea, cough and wheezing bring us the pathetic picture of 'status asthmaticus'. While there are many theories regarding the mechanism of bronchial obstruction in asthma, we may say for practical purposes that it is due to a spasm of the smooth muscle which constricts the bronchial tubes, whose diameter is further narrowed by edema of the mucosa. The stimulus may arise either in the bronchial tube itself or reflexly from more distant organs and is probably carried through the vagus nerve.

Three main groups of asthma are:

I. Bronchial: with the primary cause in the bronchi or lungs. This may be either:

  a. Allergic: when the attack is directly due to a specific allergic reaction.
  b. Non-allergic: when the cause is extra-pulmonary and not due to specific sensitization.

II. Cardiac: due invariably to rheumatic or hypertensive heart disease.

III. Endocrine: in which there is some endocrine disturbance.

Allergic bronchial asthma depends primarily on two factors:

  a. Natural constitutional predisposition.
  b. Adequate contact with specific sensitizing agents.

Heredity is the most important factor in the first group. Possible factors in the second group are similar to those in the production of perennial hay fever: pollens, animal danders, foods, bacteria, fungi, and various dusts.

Diagnosis is not difficult. A history of repeated attachs of dyspnoea, wheezing and productive cough with varying periods of freedom between spells, the presence of other allergies in the patient or his family, and relief by adrenalin usually suffice. There is an increased blood and sputum eosinophilia and under the fluoroscope the hilus markings are greatly increased. However, as has been repeatedly shown, all is not asthma that wheezes. Differentiation must be made from chronic bronchitis, cardiac disease, fibroid or glandular tuberculosis, foreign bodies in the bronchi, emphysema, bronchiectasis, and silicosis. Particularly important is the differential diagnosis from acute pulmonary edema or cardiac asthma, which we see in children following rheumatic heart disease or in elderly people with hypertension or coronary disease.

Treatment. There are two main types of treatment in asthma.

I. Symptomatic — the treatment of the immediate attacks.

II. Prophylactic—the elimination of the offending factors and desensitization where this is not possible or practical.

The repeated injection of adrenalin chloride (1:1,000) is our most valuable single therapeutic measure, and may be used together with adrenalin in oil, which has a slower but more prolonged action. In emergencies, a slow intravenous infusion of 500 cc. of glucose (10%) containing 1 cc. of adrenalin (1:1,000) gives startingly good results. The inhalation of adrenalin 1:100 in a wide-mouthed nebulizer: ephedrine, propadrin, neo-synephrin, and other synthetics will aid mild attacks. Morphine should never be given. The intravenous use of aminophyllin and the inhalation of a helium-oxygen mixture are frequently invaluable. Rectal use of ether (6 ounces) in oil is an excellent sedative during attacks.

In the more chronic forms of asthma, the use of expectorants, antispasmodics and sedatives are indicated, and X-ray therapy may help patients with enlargement of the tracheobronchial glands. In a large series of cases over a period of years I have found that the intra tracheal administration of varying strengths of iodized oil has been the most valuable single therapeutic aid.

Prophylactic treatment consists of the elimination of the specific irritants, together with specific and non-specific desensitization. With allergens like foods and animals, the avoidance of contact is relatively simple. With pollens and dust this is more difficult, and here the patient's tolerance may be increased by the perennial method of specific desensitization. Vaccines, preferably autogenous, should be used where there is definite sinus and bronchial infection, and radical surgery is indicated in the suppurative types of sinusitis.

The prognosis as regards attacks and longevity is good. Death from asthma does occur, but is not common and is usually due to complications. A cure depends on many factors: the age of the patient; duration and type of the asthma; and the extent of complicating factors.

IV. Alimentary — Gastro - Intestinal Allergy.

This condition accounts for a large number of clinical symptoms in the gastro intestinal tract and is due either to inherited or acquired sensitivity of the living cells in the mucosa with a localized swelling similar to hives or angioneurotic edema. It is invariably caused by foods, the most common of which are milk, eggs, wheat, fish, nuts, chocolate, pork, and beer. Symptoms may mimic any lesion of the gastro intestinal tract. We encounter canker sores, edema of the lips, tongue and mouth, nausea, vomiting, abdominal pain; diarrhea, colitis and gastro-intestinal bleeding. Diagnosis should be differential in character, and care must be taken to rule out organic disease. Following this, the etiological factors are determined by means of history, intradernal skin tests and clinical trial. Treatment is similar to that in other allergic conditions.

V. Skin Allergy.

Various forms of skin eruptions, chiefly eczema, both the atopic and contact types, urticaria and angio-neurotic edema, depend on a hypersensitive condition of the skin and subcutaneous tissues.

Natural or atopic eczema occurs chiefly in children or young adults, affects the flexor surfaces and is usually due to foods. Intradermal skin tests are positive, as there is a specific allergic antigen antibody reaction. It is frequently a forerunner of later hay fever and asthma, and diagnosis at this stage affords an excellent opportunity for preventive medicine.

In the acquired or contact eczema, there are no circulating antibodies and tests should be done only by direct application of the specific irritant to the skin, as in the patch test. Itching is the most common symptom in both types. Chief among the causes in contact eczema are cosmetics and hair-tonics; chemicals, clothing, such as wool or furs, the oily portion of plants as pollen oils or poison-ivy, and materials frequently used in industry, such as metals, dyes, rubber and paint.

Treatment consist chiefly of the elimination of the offending food or agent. Antipruritic lotions, tar and X-ray are valuable therapeutic aids.

Urticaria and angio-neurotic edema are allergic skin manifestations which appear as small or large itchy swellings or wheals, depending on the involvement of either the upper or deeper layers of the skin. They frequently occur together and may be hereditary. Emotional upsets, chronic infections, coffee and alcohol will precipitate attacks. The most common causes are foods, physical agents, such as extreme cold or sunlight, and bacteria, as seen in serum sickness following serum injection.

Diagnosis is similar to that in other allergies. Because of the marked dermatographia, only the intradernal method of testing is feasible. Food elimination diets aid greatly in treatment. With the exception of autohemotherapy, nonspecific treatment is generally disappointing. I have had no results from the use of calcium, peptone, hydrochloric acid or histamine.

VI. Migraine.

This is a unilateral, periodic, extremely intense headache accompanied by visual disturbances, nausea and vomiting. There is a marked hereditary factor. Usually occurring in adult women, it is closely related to puberty, menses, and menopause. The principal factors are foods and drugs; with fatigue, eye-strain, nerves excitement and worry as precipitating causes. Treatment should be supportive, and the withdrawal of offending foods and drugs.

VII. Drug Allergy.

This may be defined as a skin eruption and transient fever occurring in certain people following the administration of a drug which is non toxic for the average person. It is quite similar to serum allergy; the difference consisting chiefly in the substitution of a chemical agent for the serum. Among the common causes are (a) alkaloids from aspirin, quinine, and belladonna; (b) metals as mercury and arsenic; (c) bromides and iodides; (d) coal-tar and benzyl derivatives as antipyrene, iodoform, salicylic acid; (e) endocrine or glandular products as insulin, thyroid, and ovary, (f) phenolphthalein and the barbiturates. Effects may be produced by either injection, ingestion, contact or inhalation.

Treatment consists of recognition of the specific agent by the patient's history and intradermal skin tests. Once determined, its avoidance will prevent further attacks.

IX. Bacterial Allergy.

This term is used to designate abnormal reactions of body tissues to the presence of living bacteria and their products, or to extracts prepared from them. It is sometimes called bacterial hypersensitivity or hypersensitivity of infection. There is no subdivision of allergy more complex, and I shall mention only its relation to common clinical allergic symptoms. We know that in certain patients the presence of infection in the paranasal sinuses is related to both rhinitis and asthma; and excerbation of this infection or the injection of cultures taken from these infected foci will precipitate an attack of coryza or asthma. Proper treatment of the infected foci frequently brings startling improvement in the patient's allergic condition. Although evidence has been produced to show the hereditary or atopic character of this sensitivity, the more generally accepted belief is that it is acquired. The common offending organisms are: staphylococcus albus and aureus; strept. viridans and hemolyticus; pneumococci; b. fredlander and b. coli. Skin testing is done with specific bacterial antigens, and while we may see an immediate reaction with typical wheal formation and passive transfer, the delayed positive reaction is more common and of greater diagnostic importance. A history of onset of allergic symptoms after forty, which become worse during damp weather and winter, with an unusual amount of cough and expectoration, point strongly to bacterial sensitivity. Patients become more subject to colds and bronchitis, with symptoms more severe in the morning and night. The nasal secretion and sputum becomes thick, yellow and purulent, polyps are frequent, and the entire picture is one of infection. Both the stock and autogenous type of vaccines, may be used in treatment, but in my experience the autogenous types, carefully used, have been by far the more successful. The interval between injections and the size of repeated doses should be governed by the intensity of both the local and general reactions.

In conclusion, may I repeat that the treatment of allergic symptoms is merely a part of the general therapy of the individual as a whole, in which the allergist can function best only in close cooperation with the physician in general practice.

☆☆

A BUSINESSMAN'S APPEAL

An address by Mr. J. Howard J. Pew, member of the Board of Trustees of Jefferson Medical College of Philadelphia, before the alumni dinner of that organization on June 6, is quoted in part by *The Journal of the American Medical Association* for July 6 as follows:

" 'I appeal to you men of the medical profession to come to the defense of our American system of free enterprise and equal opportunity, for the truth is that no economic planning authority could possibly have foreseen, planned, plotted and organized such an amazing spectacle of scientific, medical and industrial progress as the world has witnessed right here in America during this last century. No trust or combination, private or governmental, could have accomplished it. It could have been achieved only under conditions where there was wide-open opportunity for all the genius, inventive ability, organizing capacity and managerial skill of a great people.'

"*The Journal* appreciates the compliment in this appeal," it declares. "And we would appeal to American business to recognize that the regimentation of medicine would be the first insidious step in this country, as it has been in every other country in the world where it was established, toward a regimentation of all the actions of human beings. Eventually this leads to that descent into brutalism and lack of consideration for the individual human being which characterizes all totalitarian governments."

NEW PRODUCT:

The Professional Equipment Company of New Haven is now demonstrating the new Keleket portable x-ray machine for office and home use. It has a capacity of 15 MA at 80 KV. New features include a twenty-four step auto transformer, and a direct reading kilovolt meter. It is carried in three cases of less than forty pounds each. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

The Connecticut Way

The State Medical Society's Participation in Public Health*

JOSEPH I. LINDE, M.D.,

New Haven, Conn.

The fields involved in the newer definitions of public health are broad. This Society was familiar with some of these new aspects many years ago. By its efforts and the interest of its members the initiative in many of the fields (now known as new) which involved the health of the people was launched. Medical education and licensure, establishment of community hospitals, (voluntary and official), mental hospitals, early adventures in mental hygiene, sanatoria for the tuberculous, training schools for physically and mentally handicapped children, veterans' hospitals, maternal and child health projects, are noted in the records of the Society.

Significant developments in scientific medicine have come rapidly in the last half century. Achievements in almost all branches have been prodigious. With these developments the scope of public health has widened even beyond the horizon which our predecessors envisioned.

The greater use of physical and chemical sciences, a greater application of biological discoveries, the blooming of psychiatry and mental hygiene, the vast improvement and the change in the functions of hospitals and the introduction into the setting of medical social service, coupled with our recent economic depression have placed much greater responsibilities on our profession in its relation to the people and the state.

These responsibilities which I believe we are willing to share and in certain instances assume, may seem remote to the practice of medicine but are necessary so that the facilities and resources of our state may be used for the advantage of our people.

In some spheres the official agencies have sought our assistance, in others, we have gone forward on our own in order to better solve some of the problems of medical administration and economics.

Child and maternal hygiene programs, as regards well baby conferences, pediatric consultants, and procedures at conferences, and the crippled children's program have presented many complex situations. The administrative intricacies of all phases of obstetric service for women who cannot afford private care have also presented difficulties. Careful consideration by the Public Health Committee in conference with the commissioner and bureau heads of the State Department have usually resulted in satisfactory decisions. These conferences have not merely been cheerful assents but sessions where the problems presented have been really seriously considered. Integration of ideas of these two groups has brought to the state an excellent and reasonable program in these services. The local and county societies, as well as the state, are also actively participating.

This Public Health Committee has taken an active interest in venereal disease control and two years ago conducted a prevalence study which far from complete, however, brought to the attention of the physicians certain significant data in regard to these diseases.

Full cooperation between this committee and the official agency made possible a fine series of meetings on pneumonia control.

Several other situtations with public health implications have been considered.

The industrial hygiene program now being undertaken has closely coordinated its plans with the program of the state bureau as well as with the manufacturers and other groups.

From this type of coordinated plan, industry will not only benefit from the improvement in the environment of the worker and the elimination of specific industrial disease hazards but will also profit from the broader conception of disease and disease prevention which the well trained physician is able to place in the picture. He may also advise not only in the prevention and treatment of injuries, but also in the fields of communicable disease prevention (especially tuberculosis and syphilis) and in the detection and prevention of nutritional disturbances. Avitaminosis and other deficiency conditions may produce symptoms which are hazardous to the employee and his fellow workers, aside from the slowing up of production. Instruction in diet and in nutrition is a function of the industrial physician and his department.

---

*President's Address read at Annual Meeting, Connecticut State Medical Society, Hartford, May 22-23, 1940.

In cancer control, the joint program sponsored by the Health Department and the Society, has made statistical and clinical information available to professional and lay groups. The handbook prepared by these groups and financed by the state is outstanding. Much publicity and educational material about cancer has been presented to lay and professional people.

Another cooperative venture of note has been the serious and intensive study of the school health programs. This study was instigated by the State Department of Education. Four of this study group (which consists of educators in several fields, a school nurse, heads of public health nursing organizations, dentists and physicians) are members of our Society and by the nature of their specialties are deeply interested in child hygiene. These men have been able to interject the new points of private medicine and public health into this study. All over the country these school programs are undergoing review and will probably be rewritten with an important principle, as far as relationship with the medical profession is concerned, being stressed. This principle is: The school physician should be a health counsellor, an advisor in regard to the health of the pupil and in relation to the school in all its phases. The problems of prevention and treatment of disease and the correction of defects in the individual child should be placed in the hands of the family physician. The acceptance of the medical viewpoint by this group and the spirit of all parties wishing to do a good job is refreshing.

The Clinical Congress Committee has consistently kept before the membership subjects coming into the classification of public health. The newer concepts of the causes of some of the infectious diseases, of immunization and methods of procedure, and new therapeutic measures have been discussed.

The widespread prevalence of nutritional disorders and the inadequacy of diets have placed nutrition in the category of public health. This subject has held an important place in the programs of the Clinical Congress.

Tuberculosis, its prevention and treatment, has long been of public concern. Any chronic disease which may place a great financial burden on the individual, such as mental disease and tuberculosis, is usually for most people financed by government.

Any disease in which the control is dependent upon breaking the chain of infection is public health business, of course in cooperation with the family doctor.

You have recognized these points by your long time cooperation in the tuberculosis program carried on in this state. In 1935, the House of Delegates endorsed a state-wide case finding tuberculosis project, which helped in bringing forward this important part of tuberculosis control.

I have attempted in the preceding to offer a few examples of the Connecticut way of participation as regards the practice of clinical medicine with official and non-official public health agencies.

Now may I bring to your attention a few of the efforts of your Society which deal with administrative and state medicine.

The direction of these efforts has been in four general ways:

1. Studies by committees of the Society;
2. By joint committees of the Society and other agencies;
3. By consultants from the Society, official and non-official agencies having sought information, advice and guidance in many kinds of medical affairs.
4. By official appointments of members of the Society to state and local commissions and boards.

We are indebted to our executive secretary for his vision in bringing many of these problems to the attention of the Society and for his skill in steering our vessel through the difficult channels of relationships.

Prepayment plans for hospital care have been considered by several of the Society's committees and with changes in types of service rendered by some hospitals, must be further studied. These plans have increased private patient utilization of the hospitals and have added new problems which are of vital importance to the hospitals and physicians.

Along with prepayment hospitalization comes the question of prepaid medical care which your committee is earnestly considering.

I am sure you are not opposed to reasonable methods of insuring the costs of illness and would welcome a method of voluntary health insurance more inclusive than the hospital care plan and which should be administered in a method satisfactory to the public and the profession.

The cost of medical care has advanced, and so has the quality, twofold perhaps, in proportion to the cost. The horse and buggy day has passed and no one of us would ever be satisfied to have patients receive care not in keeping with modern medical standards. With many people it may be advisable to budget the cost of medical care by spreading the cost through groups and, if this is going to be the way, we must continue to study and possibly experiment with voluntary plans, taking into consideration medical service, actuarial experiences and the demand for the service.

Diligent work with enlightening results in this field have come from your committee, which has consulted many official and non-official agencies in its studies.

Committees from our Society and other professional organizations have deliberated on problems in which there have been joint interests. The Hospital, Nurses', Dental and Pharmaceutical Societies are some examples of joint participation and good constructive actions have resulted.

Protection of the standards of medical practice has also been considered, not only by the Legislative Committee but by a special committee which was appointed to examine into some particular impending adverse legislation.

The act authorizing the governor to appoint a Commission to Study Medical Care in the state was in line with surveys which had been suggested by the American Medical Association and had been conducted in other states.

The survey, authorized by the state, is much wider in scope than most of these other studies and allows the Commission "to study the problems presented by the physical and mental disabilities of the people of the state, enquire into the expenditures for prevention and the care of people afflicted." (Special Act, 1939-548). This Commission was not intended to be an investigating body in the usual sense of the word but was to be a fact-finding organization. With your executive secretary as chairman, another member of your Society, a specialist in hospital administration, and a public health authority with broad public health organization experience, together with other competent men, this Commission is in strong position to interpret their gathered data, not only from the viewpoint of expenditures but also from the medical viewpoint. This gives assurance that the recommendations resulting from this study will be reasonable and for the good of all.

In the last two years several of our members have given service to the Personnel Department of the state. They have studied proposed qualifications and have served on examining boards for medical positions in the Health Department and in the various state institutions. The merits of a candidate for a medical position should be decided by men who have a good knowledge of the duties involved in the position and are able to enquire into the candidates ability.

It should be thus, but nevertheless, it has not always been so.

During the last few years, several members of the Society have been appointed by the Governor to responsible positions on commissions and boards. In most instances the wisdom of the choice has been reflected by the work of the agency.

These are just a few ways in which you have participated in the business of, and in state medicine.

It is extremely difficult to evaluate either of these efforts. We do know we have healthy communities and if the measure of health can be judged by our maternal and infant mortality rates, by our low communicable disease prevalence rate, by the continued freedom from smallpox, by the extremely low incidence of milk and water borne disease, and by the records of our cities in the national health conservation contests our cooperative efforts with the state have been wonderfully fruitful.

We know we are using and pooling our resources and our facilities to wipe out the venereal diseases and to control tuberculosis. We are well aware of the inadequacy of the facilities for the care of the mentally ill and the necessity for extending these facilities. We appreciate the importance for further fostering the mental hygiene movement and the psychological approach to health, etc., etc. By this knowledge we have and are focusing attention on these needs with an outlook for improvement.

However, we are able to advance even more in this mission of ours. Public health is the specialty that views the sweeping generalities of health, private medicine sees the individual. Both should see the personalities. A little more individuality in public health and a little wider perspective by the physician would be good medicine for the community as a whole and for the individual.

Years ago, we began to emerge from the clam shell of mysticism which medicine has been accused of inhabiting; relations with quasi medical and other groups were established. These groups of voluntary agencies of great varieties have welcomed contact with us. The last year a few of your officers have acted as a speakers' bureau and on these men has evolved a Herculean task. The demands have been so great that refusals were occasionally necessary. This properly is a function of the Public Relations Committee and is mentioned in their report.

It is not difficult to see that visits and talks to lay groups are of great value in improving relations, and also in health education. This practice should certainly broaden the scope of private physicians' interest. Opportunities to become interested in individual medicine are ever present in public health, simply by a little more consideration for the private physician and by a little keener focus, in looking at problems from the doctor-patient relationship.

The Society has accepted the challenges placed before it in both the scientific and administrative branches of practice.

In conclusion may I use some of the words of my initial presidential message by saying: We are considering calmly, deliberately, with the spirit of progressiveness and in the light of past experience and tradition, all these challenges that are now placed before us — considering them with the spirit of cooperation and voluntary participation — "The Connecticut Way" — for the health and good of our people.

☆☆

THE CUSHING MEMORIAL LIBRARY AT YALE

The left wing of the new medical library now under construction at the Yale School of Medicine will be known as the Cushing Library in honor of the late Harvey Cushing. To the great collection on historical medicine left by Dr. Cushing will be added the collections of Professor John F. Fulton of Yale and of Dr. Arnold Klebs of Switzerland. The Cushing Library, in the opinion of Yale authorities, will represent one of the most important collections dealing with the history of medicine and medical sciences in the world. This portion of the building will house about four hundred thousand books and is expected to be ready for occupancy in September, 1940. The right wing, or general medical library, is to be administered by the Committee on the Library of the School of Medicine under the chairmanship of Professor George H. Smith. On the second floor of the new building will be located the offices of the administration for the School of Medicine, and on this floor also it is planned to locate the Beaumont Memorial Room, which will house the Beaumont collection of medical memorabilia and in which meetings may be held.

WEATHER MAKER:

For the first time there is now available a perfected and easily installed air conditioner which will really cool the doctor's office at a very nominal cost. Simply plug it in and it will cool, filter, dehumidify, change, and circulate the air. The Professional Equipment Company of New Haven is Connecticut's distributor to doctors.

That Secondary Adenoid and Tonsil Operation

WILLIAM H. TURNLEY, M.D.,
Stamford, Conn.

There is an abundant literature on the subject of tonsil and adenoid operations, but very little has been said about those which have to be done the second, third, and fourth time, or which have to be done after electro-coagulation. Usually the secondary adenoid and tonsil operation is more difficult because of the scar tissue formation and proneness to bleeding.

Why is it necessary to do a secondary adenoid and tonsil operation? Primarily because they are not completely removed the first time. Moreover, some operations have to be done when children are very young (six months to five years of age) before the lymphatic tissue has finished its growth. At this time it is difficult to remove every little bud of lymphatic tissue. These anlage, if overlooked, still have the urge to grow and develop into adenoid and tonsil tabs later. This urge to grow ceases at puberty.

In removing tonsils the slogan should be, "All or None". Tonsils *do not grow back*, any more than any other gland in the body; but, if a piece of tonsil is left at the base, it will appear much larger on inspection the next morning and will later hypertrophy. Another condition which is misleading except on very close inspection is a piling up of granulation tissue as a result of postoperative infection. Later this granulation tissue flattens out, resembling a piece of tonsil. It is not so readily susceptible to infection, and when it does become infected there is little or no systemic absorption as there is from lymphoid material. Probably the lymphatics have become sealed off, due to scar tissue formation which prevents absorption.

There is a certain type of patient having a peculiar reaction or predilection for growing lymphoid tissue, and if a small piece of tonsil is left in such a patient it will greatly hypertrophy in a few weeks. It would be interesting if some study of this type of case were done from the viewpoint of lymphoid dyscrasia.

Where tonsils are removed by mass operation, as in clinics of the larger cities, and the Sluder instrument is used to attain speed, quite often the upper pole of the tonsil slips out of the instrument and is left hidden under the junction of the anterior and posterior pillars. This piece of tonsil does not later give much trouble from toxic absorption; but being covered with scar tissue, it is more prone to abscess formation. It sometimes acts as a foreign body, and seems to migrate backward towards the soft palate. It may be no larger than a match head and not noticeable on inspection, but its presence may be detected by the patient giving a history of an abscess after the tonsils have been removed.

Case History: A girl, age 27 years, had a tonsillectomy when she was twenty, from which time she has had repeated colds, always accompanied by a red, swollen, and very tender area on the left side of her throat at the junction of the anterior pillar and soft palate. She consulted her doctor, who sprayed her throat and gave her a gargle. This continued off and on for seven years, when she consulted a specialist during one of these attacks. An examination revealed a small remnant of tonsil tissue which was held by scar tissue between the two pillars and which acted as a foreign body. Under local anesthesia a piece of tonsil the size of a match head was dissected out leaving a wide open fossa. This has relieved her symptoms completely.

A piece of tonsil is more often left at the base, especially if there is not good light while operating, or if the patient has a very thick neck or an unruly tongue, or if the base and plica of the tonsil are caught under the tongue depressor and overlooked. Some surgeons may leave this piece at the base purposely, for fear of a bleeding vessel which is difficult to ligate. Others leave this piece in the belief that there will be less scar tissue to contract the tongue. It has been observed, however, that cases in which the tonsils have been removed close to the tongue, including the lingual tonsils, do not seem to have this contractive scar tissue any more than those in which a small piece of plica is left at the base. Many cases have been observed in which there is a contracture, so that the soft palate is drawn down towards the tongue with this piece of tonsil growing in between. In any event, a piece left at the base may hypertrophy and later become infected, causing more toxic absorption than a piece left at any other place. Sometimes these pieces are so small that they are visible only during an acute flare-up, though they may be more lethal than the entire gland. Such minute fragments, even when not acutely active, may give rise to a chain of toxic symptoms often attributed to other causes; for it is through the base of the tonsils that the toxin can drain directly into the lymph stream. They may be removed under local or general anesthesia.

Case History: A woman, age 35 years, complained every winter of several attacks of sore throat with enlarged tender glands of the left side. The attacks varied in intensity from mild to severe, and lasted a variable length of time following a cold. She also had a systemic disturbance of rheumatic twinges in the fingers, legs, and back. There was an involvement of the uveal tract of the eye on the left side. When the throat cleared up, the general symptoms also subsided. Since removal of this tonsil remnant she has been free of local and systemic symptoms for six years.

There is yet a third type of tonsil remnant found in the middle of the fossa. This type seldom gives any trouble, and can be left to the discretion of the surgeon as to whether it is causing sufficient trouble to warrant its removal.

It has been observed that after an adenoid-and-tonsil operation a piece of adenoid tissue is left more often than a piece of tonsil. This is accounted for in several ways. The blade of the adenotome may not completely close when using the La Force instrument, with the result that when the instrument is withdrawn a piece of adenoid material slips out. Or there may be a piece overlooked on either side near the eustachian tube, especially if there are several layers of adenoid. With the curette type of adenotome, pieces may be left in the form of shreds. Probably the most common cause for overlooking a remnant is that, when the adenotome is inserted, the top fold of the adenoid is pushed up into the posterior nasal choana. This remnant may drop down into the nasopharynx soon after the child is out of the anesthetic, and then it becomes adherent to the raw surface. I have seen a large piece of adenoid overlooked by an interne after he had made three examinations with his finger, each time declaring there was nothing left.

If adenoid fragments have been left to the extent that they cause trouble, it is well to remove them as soon as the condition is discovered, although small pieces may atrophy or disappear as the child grows, especially if there is sufficient aeration. Another annoying condition may develop from adenoid fragments; it is called "granular pharyngitis" and shows these little islands of lymphoid tissue over the back of the throat which are constantly being irritated from above by a discharging sinus. The throat feels dry and scratchy, usually with an accompanying cough. This condition is difficult to treat. Cauterizing with carbolic acid, silver nitrate, or the electric cautery has been found helpful, but particularly more effective is treatment of the sinusitis.

A less common condition known as Thornwaldt's disease may sometimes occur; it is characterized by a suppurating canal in the processus medius or groove between the lateral halves of the adenoid. It is due to the inflammatory adhesion of the median borders of the adenoid masses forming a canal. The lining membrane of the canal becomes infected and discharges a purulent exudate. The symptoms are those of a chronic pharyngitis and cough. The treatment is a thorough adenoidectomy.

Adults also have adenoids which are frequently overlooked when performing a tonsillectomy, and quite often no attempt is made to remove them, especially under local anesthesia. These adenoids in adults may be part of the cause of that postnasal morning drip, chronic cough, and bronchitis. This condition is often diagnosed as "just a mild sinus condition" and so it may be; but if a thorough postnasal examination is made with a laryngeal mirror, adenoid tissue may be seen. There are more poor adenoidectomies done than tonsillectomies, and we might all save ourselves embarrassment if we would use the laryngeal mirror to inspect the nasal choanae of every sinusitis case. At the same time the mirror can be turned over, and the lingual tonsils and vocal cords examined. In a child a quick examination for adenoids can be made by inserting the index finger up into the nasopharynx through the mouth. This is rather a crude method, but it is efficient, and it is often difficult to see a child's adenoids with a laryngeal mirror because of lack of cooperation. In adults an electric nasopharyngoscope may be used.

Case History: A man, age 32 years, complained of a postnasal drip and morning cough, with frequent attacks of pharyngitis and hoarseness, but no sore throat. He had undergone an adenoid-and-tonsil operation when a child; but for the past seven years he had been going to doctors and getting treatments for what he was told was a mild sinusitis, and a spray was prescribed. Examination showed a mild sinusitis; on closer examination with the mirror there could be seen at the base of the nasal septum a mass of adenoid tissue in the midline of his epipharynx about the size of a large pecan nut with crypts in it similar to pecan meat. This was removed with the La Force adenotome at one stroke, after he had been shown how to relax and hold his mouth open. Local anesthesia was used by applying cocaine 10% through the nose on to the adenoid with a long wire applicator. This was done in the office, and the patient did not seem to mind the procedure. He felt only the pressure of the instrument, and there was little or no bleeding. This patient's condition cleared almost completely, and it is just one case like many others. It would be better to discover such conditions at an early age, when, of course, it would be advisable to use a short general anesthetic such as ether or evipal.

Another type history of an adult suffering from adenoids around the opening of the eustachian tube, reveals an itching sensation in the ear, or a feeling of fullness and all the symptoms of a eustachian catarrh with otalgia or in more progressive cases even deafness. On examination of such cases with the postnasal mirror, adhesions may be seen extending from the lip of the eustachian tube to the posterior wall of the epipharynx. These adhesions have formed as a result of infection or from trauma to the cushion around the mouth of the tube during the adenoidectomy. They may be broken or massaged with the index finger which will give some relief.

There is an excellent article in The Journal of the American Medical Association, February 18, 1939, on the treatment of deafness in children by Doctors Crowe and Baylor of Johns Hopkins University whereby this adenoid material around the mouth of the eustachian tube is treated with radium.

Case History: The following, of a boy five years of age, is an extreme example of adenoid material being left after a clumsy operation at the age of eighteen months. The family physician did the operation without any anesthetic, while the mother held the child sitting in a kitchen chair.

An examination revealed that the child could not breathe through his nose; that the tonsils were completely removed, and also the anterior and posterior pillars on both sides as well as the uvula. Adhesions had formed so completely that there was only a small opening about the size of a match stem in diameter between the oropharynx and the nasopharynx. The nasopharynx was full of adenoids, which were removed after the opening was enlarged. To keep this denuded area from growing together again, a rubber tube the size of a pencil was inserted in the right side of the nose and out the mouth, the ends fastened together with a safety pin. Another tube was inserted in the left side of the nose in a similar manner. These tubes were left in place for six days; then they were removed, and the patient sent home apparently cured. A week later he was seen, and the pharynx had grown together as completely as though nothing had been done. Again the patient was hospitalized and the procedure repeated. The tubes were left in place this time for twelve days, with very little improvement in the results, though the opening was patent enough so he could breathe through his nose. A peculiar reaction of this scar tissue formation seems to be a constant tendency to contract in spite of all precautions; and the more the adhesions are cut, the greater the urge to re-form in some cases. In other cases there is little or no tendency to contract. When there is only a small amount of scar tissue, it is better to leave it alone so far as surgery is concerned. Instruct the patient to stretch this area daily by massaging with the fingers, by yawning and by chewing gum. Why some individuals have this tendency towards scar tissue formation is difficult to explain.

Hypertrophied lingual tonsils are difficult to treat. These patients give a history of a feeling of fullness in the throat when they have a cold. Sometimes they have difficulty in swallowing, an excess of saliva, and nearly always there is enlargement of the anterior cervical lymph glands with tenderness and a general malaise. One has to use one's own judgment as to just how much lingual tonsil to remove. If they are large and obviously infected they should be removed; but if they are sessile in character, and extend to the foramen caecum of the tongue, they should not be removed.

The treatment of some of the cases at best is rather unsatisfactory, though conservatism is still the better course to follow.

Unusual Case of Pancreatic Abscess

PETER J. STEINCROHN, M.D.,*
Hartford, Conn.

The following case report is presented as one of circumscribed pancreatic abscess.

Although a few similar abscesses of the pancreas have been described, none have caused the obstructive signs found in this patient.

Baldwin[1] reported a case in which an abscess three centimeters in diameter was found in the head of the pancreas. In it was a toothpick. The abscess cavity had ruptured into the hepatic and pancreatic ducts causing ascending suppurative cholangitis and multiple liver abscesses. There were also multiple abscesses in the lungs. Bile was demonstrated in the stools. An elevation of the right diaphragm was seen on chest x-rays.

Batchelor[2] reported a case of pancreatic abscess with common duct stones; Ochsner[3] a case of abscess in the tail of the pancreas secondary to an infection originating in a perforated gastric ulcer which later proved malignant; Brewer[4] one case with an abscess in the head of the pancreas and another case with one in the middle of the body of the pancreas. Davis[5] reported the case of a physician of forty-five who complained of indigestion, occasional clay colored stools and stones passed per rectum. He had slight fever and marked tenderness over the gall bladder region. The pre-operative diagnosis was empyema of the gall bladder. At operation the gall bladder and bile passages were normal. Six to eight ounces of pus were drained from the body of the pancreas. No source of pancreatic infection could be found. Gastric and duodenal ulcers were not a part of the picture. One year after the operation the patient was symptomless except for a residual post-operative ventral hernia. Bevan[6] reported an abscess of the pancreas developing one year after the removal of gall stones and drainage of gall bladder in presence of a pancreatic mass of unknown etiology.

Eisendrath and Goodkind[7] reported a case of pancreatic abscess following sub-acute pancreatitis. Archibald states, according to the above authors[7], "that the pancreas is rarely the seat of bacterial inflammation. Cultures from all but the frank abscesses, which are rare, are usually sterile."

CASE REPORT

A. L., white male, aged 74, single and a painter by trade was admitted to the Municipal Hospital on February 2, 1939, complaining of 'yellow skin'. Habits, family and past history were unimportant.

Present Illness: Four days before admission a friend remarked to the patient that his skin was yellow. This was the first indication that anything was wrong, as the patient had no subjective symptoms at that time. In the intervening four days the icterus increased in intensity. Stools became clay colored and appetite diminished. There was some frequency of urination and nocturia. His urine was very dark on the morning of admission. There was no dysuria, burning, pruritus, cough, sore throat or fever. Abdominal discomfort, nausea, and vomiting were absent. Since the onset of the icterus, the patient had felt a mild discomfort in his right mid-back. He had lost about six pounds in the past two months.

Physical Examination: Positive findings revealed a well developed and nourished, elderly white male weighing 180 pounds He was in no discomfort His skin and sclera were icteric His chest was of the emphysematous type with no rales in the lungs. Heart negative. Blood pressure, 164/86. The abdomen was protuberant, liver was enlarged downward. The edge was smooth and tender and about two inches below the costal border. Spleen was not palpable. There was slight bulging at both flanks with questionable fluid wave. The prostate was moderately enlarged but not tender.

Admission Impression: Carcinoma of head of the pancreas.

Summary Findings

On admission the chart indicated temperature 99.4, (rectal), pulse 90 and respirations 20. At exodus temperature 99; pulse 130; respirations 50.

There was no fever the first week. From the second week on there was an irregular fever with most elevation at 4 and 8 P.M., the highest temperature recorded being 102.4.

---

*Attending Physician Mt. Sinai and Municipal Hospitals, Hartford, Connecticut.

X-ray of Lungs: 2/16/39 showed no evidence of parenchymal consolidation. 2/26/39 there was evidence of chronic bronchitic changes and emphysema. X-ray of gastro-intestinal tract 2/6/39 was negative.

2/2/39 electrocardiographic examination negative; 2/3/39 Wassermann and Kahn negative; 2/11/39 bleeding time, 50 seconds; coagulation time, 2 minutes; 2/3/39 hemoglobin 86%; red blood count, 4,000,000; 2/3/39 white blood count, 7,900 (normal differential); 2/16/39 white blood count 15,000 (differential); neutrophiles 80%; 3/4/39 white blood count 16,300, neutrophiles 92%.

Glucose Tolerance 2/9/39

	Blood Sugar	Urinary Sugar	Acetone
Fasting	143	0	0
1st. hour	236	0	0
2nd. hour	245	3%	0
3rd. hour	286	3%	0

Sputum, examination: 2/15/39 Organism group IV pneumococcus; Sputum for tuberculosis negative on four occasions. Good Pasture test negative 2/3/39; Vanden Bergh 2/4/39 Direct reaction: immediate; indirect reaction: 4.6 mgms. per 100 cc. Icteric Index: 2/4/39—70; 2/6—75; 2/23—105; 2/28—125.

Daily routine urine examinations showed: good concentration, acid reactions, occasional positive albumin. The urine was positive for sugar on three or four occasions. Bile was present. Acetone not present and the microscopic examination unimportant. Ehrlichs test for urobilinogen was negative in all urine examinations.

On 2/6/39 examination of feces for occult blood: negative; for urobilin, slightly positive (Schmidt's test). The next five consecutive tests for urobilin in feces were negative. (2—11/15/16/17/18).

Hospital Course: When the patient entered the hospital he was perfectly comfortable. He was placed on a low fat, high carbohydrate diet. After one week on the medical wards he was transferred to the surgical service with the view to exploratory operation. A few days after the transfer proposed surgery was not performed due to the onset of an upper respiratory infection. Following this the patient developed cough, fever, and crepitant rales at both posterior lung bases. He was returned to the medical service. His condition remained obstinate to treatment. He died on March 16, 1939.

Ante Post Mortem Diagnosis:

1. Carcinoma of the head of the pancreas.
2. Generalized arteriosclerosis with:
   a. Hypertension
   b. Regular sinus rhythm
   c. Class I
3. Terminal broncho-pneumonia.

Abstract of Post Mortem Protocol with listing of positive findings. (Autopsy performed by Dr. Perry Hough at 11 A.M., March 17, 1939).

Positive Gross Findings:

1. Obese white male showing three plus icterus of skin and conjunctiva.
2. Lungs:—Slight edema and congestion with the beginning bronchopneumonic type of consolidation in both lower lobes.
3. Spleen:—Weight about 400 grams forming a typical acute splenic tumor.
4. Liver:—Weight 2,600 grams, dark green in color.
5. Gall bladder:—Tremendously distended. No calculi present. Common bile duct is dilated up to two centimeters in diameter. The obstruction to the duct as it passes through the pancreas is not absolutely complete. There is no evidence of carcinoma.
6. Pancreas:—At the head of the pancreas there is an abscess cavity 2½ centimeters in diameter filled with thin, purulent fluid. This abscess forms an obstruction to the common and to the pancreatic duct. Through the body and tail of the pancreas there is increased fibrosis with a few areas of fat necrosis.
7. Culture of the Pancreas:—Bacillus Proteus four plus.

Positive Microscopic Findings:

1. Pancreas:—Section from the head of the pancreas shows necrosis with slight acute inflammatory reaction. Elsewhere through the head, body and tail there is distortion of the gland by fibrous tissue associated with a three plus small round cell infiltration. Areas of fat necrosis are present.
2. Liver:—Marked bile stasis.
3. Kidneys:—Edematous with degeneration of tubular epithelium.
4. Lungs:—Beginning broncho-pneumonia.

Anatomical Diagnosis:

1. Abscess of the head of the pancreas.
2. Obstruction of the common bile duct.
3. Chronic pancreatitis.
4. Broncho-pneumonia (bilateral).
5. Icterus.

Comment

The icteric eyes of the patient whose bile balance has been disturbed challenge the clear vision of the physician to see what goes on behind the scenes. The differential diagnosis of the causes of icterus is well known. Unfortunately, its application to the individual patient is not always without difficulty.

The normal bile balance can be disturbed easily with the production of icterus, if any of the factors found in the following simple classification are present.

a. Extrahepatic disease: — such as common duct stone, stricture, or carcinoma of the head of the pancreas.

b. Hepatitis (Intrahepatic disease): —such as caused by arsenic and phosphorus poisoning; portal or biliary cirrhosis; infections like pneumonia or sepsis; or multiple liver abscesses.

c. Hemolytic Icterus: — may be caused by any condition which produces abnormal stimulation of the reticuloendothelial system with excessive formation or destruction of hemoglobin and its subsequent conversion into bilirubin.

Except that this patient was not emaciated or anemic and did not have a low hemoglobin or red blood count, he presented the picture of carcinoma of the head of the pancreas. He had a steadily increasing, painless jaundice with history of weight loss. The autopsy showed a distended gall bladder and there was absence of urobilin in five consecutive stool examinations.

Much importance was placed on this last factor. In view of the direct Vanden Bergh and persistently absent urobilin, a diagnosis of carcinoma was entertained. The patient was transferred to surgery with view to cholecystenterostomy.

The negative feces urobilin was used to rule out silent common duct stones. In the latter condition, due to the ball and valve action of this type of obstruction, some bilirubin would have slipped by into the intestines and have been converted into urobilin and given a positive reaction in the stool. This happens rarely in obstruction due to carcinoma of the pancreas head.

It is interesting to note that the first urobilin stool examination soon after admission was slightly positive. This was probably due to the fact that when the patient first came in, the abscess was too small to cause complete obstruction. Incidentally, there was no fever at this stage.

The autopsy report states that the obstruction to the bile duct was not complete (slight pressure allowing some bile to pass through). Nevertheless, complete obstruction during life can be explained on the basis of surrounding inflammatory reaction and edema.

Irving Abell[8] writes: "In 60% of all individuals the terminal portion of the common duct is entirely surrounded by pancreatic tissue; this anatomical arrangement allows compression obstruction when the pancreatic tissue surrounding the duct becomes markedly involved in the inflammatory process, giving rise to jaundice and further impairing the digestive function."

Post mortem examination revealed no definite indication of the etiology of the abscess. No ulcer of the duodenum or stomach was demonstrated. There were no gall stones. No cancer was found. The absence of abdominal or any other discomfort prior to the onset of the icterus is against the probability of this patient having had an extensive acute pancreatitis preceding the abscess formation. The significance of Bacillus proteus in the abscess cavity is not clear.

The presence of chronic pancreatitis is born out by pathological findings and supported by the glucose tolerance curve which was definitely abnormal. The few areas of fat necrosis suggest that sub-acute pancreatitis became engrafted upon a chronic pancreatitis. The disease in some manner became self-limited, a small area in the region of the common duct became necrotic and resulted in the formation of a circumscribed abscess. This in itself, plus secondary inflammation and edema, was sufficient to completely obstruct the common duct and simulate pancreatic malignancy.

It is evident that any patient who appears to have an inoperable lesion in the head of the pancreas or anywhere else along the biliary tract, should be given the benefit of surgery.

REFERENCES

1. Baldwin, Robert S. Marshfield, Wisconsin. "Foreign Body Abscess of the Pancreas" June 1, 1935, Vol. 104, No. 22, P. 1990.

2. Batchelor, Roger B. Palmerton, Pennsylvania. "Pancreatic Abscess Associated with Common Duct Stones" Penn. Med. Jr. March 1929, Vol. 32, P. 426.

3. Ochsner, Albert J. Chicago, Illinois "Drainage of Abscess of Pancreas" Ann. Surg. 1921, Vol. 74, Pg. 434.

4. Brewer, George Emerson. "The Technique of Draining Circumscribed Abscesses of the Pancreas" Surg. Gyn., and Obst. 1907, Vol. 3, P. 344.

5. Davis, Carl B. "A Case of Pancreatic Abscess: Result One Year after Operation" Surg. Clin. Chicago 1917, Vol. 1, P. 651.

6. Bevan, Arthur Dean."Surgical Clinics of Chicago" 1919, Vol. 3, P. 1099.

7. Eisendrath, Daniel N. and Goodkind, Maurice Michael Reese Hospital. "Subacute Pancreatitis (Pancreatic Abscess) Surg. Clin. Chicago 1919, Vol. 3, P. 1367.

8. Abell, Irving. "The Diagnosis and Treatment of Surgical Lesions of the Pancreas" Proc. Interstate Post Grad. Assembly of N. A. 1935, P. 365.

The Relation of Pain Relieving Drugs to Respiratory Morbidity*

RALPH M. WATERS, M.D.,
Madison, Wisconsin

At the Wisconsin General Hospital one out of every three or four patients who develop post operative respiratory complications dies, and it is believed that these results are not incomparable with those from other localities. Since much of the respiratory morbidity is directly related to the effects of the widely used pain relieving drugs, it is felt that the general management accompanying the administration of these agents is of vital importance.

These drugs act to impair respiratory function by inhibiting the cough reflex, by inhibiting the normal ciliary motion, and by increasing the minute volume exchange of respiration. The minute volume is decreased by the combination of (1) central drug action and (2) direct respiratory obstruction, the result of muscular relaxation. With cyclo-propane, paraldehyde, tribromethanol, sodium phenobarbital, pentothal and morphine sulphate we get all of these effects in varying degrees. The combination of morphine and scopolamine has been shown to have a definite advantage in that minute volume exchange is not considerably decreased.

There are various physical, mental and age factors which affect the dosage of these drugs. Consequently, there are always bound to be estimated doses. For these reasons it is strongly felt that treatment for the relief of pain should not be routinized, but that on the contrary there should be individualization of methods and dosage. In way of management one must constantly bear in mind the following considerations:

1. Maintenance of normal minute volume
2. Maintenance of normal atmosphere
   (a) High oxygen atmosphere
   (b) Physical methods
      (1) Prophylactic stirrup—described as a one-fourth turn every 15 minutes, an endeavor to force the patient to breathe deeply and to cough frequently.
3. Relief of respiratory obstructions
   (a) Use of artificial airways
   (b) Best position of mandible with regard to cranium and of head to trunk for provision of a patient airway.
4. Recognition that there is always increased CO^2 in the blood where these drugs are used. With excess CO^2 there is a concomitant circulatory disturbance, often first manifested by a rise in blood pressure and in the pulse rate.
5. The need for early recognition and treatment of respiratory morbidity,

The author feels that those patients who are in respiratory distress as the result of pain relieving drugs have been grossly neglected and the above points are stressed in an effort to halt this negligence.

☆☆

"SOLVENT" USED IN DRY CLEANING IS NEW OCCUPATIONAL HAZARD

The recovery of a young man from the effects of a three months' exposure to a "solvent" used in a dry cleaning plant is reported by Leo E. Braunstein, M.D., Schenectady, N.Y., in *The Journal of the American Medical Association* for Jan. 13.

The case was characterized by jaundice, or yellowness of skin and eyes, brought about by the effects of the solvent, petroleum distillate (the solvent), eruption on the hands, anemia, stomach disorders and albumin and sugar in the urine. This is another occupational disorder that should receive attention, especially as the medical literature implies that it is rare for petroleum products to cause disorders of the liver. Usually they affect the nervous system.

"It has been considered safe to use 'solvent' in large quantities, and the employees handle it with impunity," he says. "I believe that the medical profession and the industry should be aware of such possibilities so that this hazard may be recognized and treated."

---

*Abstract of paper presented at the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

Association of Connecticut Tumor Clinics

Seventeenth Meeting of the Association

New Haven Hospital, New Haven
May 2, 1940

ASHLEY W. OUGHTERSON, M.D., CHAIRMAN

PROBLEMS AND ERRORS IN THE DIAGNOSIS OF MALIGNANT TUMORS OF THE CENTRAL NERVOUS SYSTEM —

Max Taffel, M.D.

Neoplasms involving the central nervous system are of common occurrence. Prior to the present century these tumors were for the most part not recognized. They were certainly not properly treated, and the patients harboring them were incarcerated and condemned to spend the remainder of their days in miserable and overcrowded lunatic asylums. Central nervous system neoplasms in general may be divided into two groups: one, those arising from the nervous tissue itself or from its meningeal and bony investments; and, two, metastatic lesions which have migrated from some distant primary focus. The former group includes the large body of gliomata, meningiomata, neurofibromata, hemangioblastomata, pituitary and pineal tumors, and such spinal column tumors as the giant cell, the chordomata, and the osteochondrosarcomata. Many of these are from the strictly oncological point of view not "malignant." They are included, however, because the devastating effects upon their hosts are often as great and occur as rapidly as those which grossly and histologically exhibit all the characteristics of malignant neoplasms. Secondary metastatic deposits directly or indirectly affecting the nervous system may take their origin from neoplasms in many different parts of the body. The common and frequent fountainheads of such dissemination are the carcinomata of the breast, lung, kidney, prostate and thyroid. Sarcomata are said to metastasize often to the brain, and nearly one-half of the cases of cutaneous and retinal malanoblastomata contain secondary tumor deposits within the cranial cavity at the time of autopsy.

The problems concerned in the diagnosis of tumors of the central nervous system are threefold: one, recognition of the existence of the lesion; two, accurate localization of the lesion; three, estimation of its exact anatomical structure. As in malignant lesions elsewhere, the ultimate prognosis is largely dependent upon the stage of the disease at which the diagnosis is made. There are many classical signs and symptoms, general and localized, irritative and paralytic, which are described in all textbooks and which, when present, point without equivocation to a lesion in the brain or cord. These are, however, often late manifestations of the disease and fall in the same category as the so-called classical signs of cancer of the breast with edema, dimpling and erosion of the skin, with deformity and retraction of the nipple, and with palpable axillary nodes. The diagnosis, to be sure, is unmistakable and easily made but the disease is already far advanced and the damage irreparable. The early recognition of central nervous system lesions demands above all an awareness of the great frequency of these lesions and the same attitude of constant alertness that is assumed for any other serious affliction.

A continuing and progressive impairment of any localized neurological function, no matter its nature or its extent, points to a lesion of the nervous system and should be investigated at once. The history and neurological examination may often be sufficient to distinguish between a tumor and a degenerative lesion. Roentgen studies of the cranium and of the spinal column may reveal unusual vascular markings, abnormal areas of calcification, or alterations of the bony structure which may not only serve to corroborate the presence of the tumor but may also offer a clue as to its localization and its histological architecture. The pineal body and the choroid plexus of the lateral ventricles, are, when calcified, additional aids in lateralization. The study of the cellular and chemical elements of the spinal fluid combined with a careful evaluation of its dynamics may yield further information. Because of the ease of their performance, the lumbar puncture and the Queckenstedt test have often been employed freely and without adequate discrimination. It should be pointed out that these procedures, invaluable and often indispensable in the diagnosis of cord lesions, are fraught with danger in the brain tumor patient, especially when the lesion is in the posterior fossa. It does not appear unwarranted to affirm categorically that the Queckenstedt test should never be performed in the brain tumor suspect. The final and often clinching step in the diagnosis and localization is the resort to ventriculography, pneumoencephalography, and lipiodol or pneumomyelography. In general, ventriculography is employed for expanding lesions anywhere within the cranial cavity; pneumoencephalography for lesions on the surface of the brain which are not accompanied with increased intracranial pressure which are certainly above the tentorium; lipiodol and pneumomyelography for suspected cord tumors. It is not always necessary to proceed serially with all of the above stages before arriving at a diagnosis. The lesion, if strategically located, may at once announce its presence and its site of residence.

The work of Cushing and his pupils over a period of about thrity-five years has demonstrated that the various intrinsic neoplasms of the brain have to a large measure certain specific and characteristic life histories as well as definite selective sites of localization by which their histological nature may be estimated before operation. These criteria are, however, merely aids in the diagnosis and are by no means absolute and foolproof. The subjective symptoms and the objective neurological findings are determined by the size of the tumor, its location and its rate of expansion. The histological architecture of the mass, its degree of malignancy and its primary or metastatic nature often have little differential effect upon these clinical manifestations, and the exact anatomical diagnosis is not infrequently made only at the time of operation. Brain abscess and chronic subdural hematoma should always be considered in the differential diagnosis of expanding intracranial lesions. The patient with a brain abscess may reveal in the history or physical examination evidence of a previous source of infection. The more common of these are otitis media, sinusitis, suppurative disease of the lungs, and localized abscesses or carbuncles elsewhere in the body. He may or may not exhibit the usual general systemic responses to infection such as an elevated temperature, a rapid pulse and a leukocytosis. The spinal fluid will usually contain inflammatory cellular elements and, unless there is also a coeval pyogenic meningitis, will be sterile on culture. Old, long-standing abscesses often become calcified and may be visualized in the roentgenogram. In chronic subdural hematoma there is usually an antecedent history of head trauma. This may, however, have occurred many years previously and may have been forgotten by the patient and his relatives. In the final analysis, even after all the evidence is accumulated, the anatomical composition of the tumor remains a matter of conjecture. One or another possibility may appear to be more likely but the truth can be absolutely ascertained only by direct exploration.

A thorough search for a distant primary carcinoma or sarcoma should be made in brain tumor suspects who are in the second half of life. The common primary sources can be readily investigated either directly or by roentgenological and other techniques. Several considerations should be born in mind in this connection. Failure to disclose a primary neoplasm even after careful and diligent search does not rule out its presence. The intracranial symptoms may occasionally be the only presenting and recognizable manifestations of the disease, and the metastatic nature of the growth in the brain may be determined only at operation. Further, the presence of impaired neurological functions in a patient with a known neoplasm does not always mean that the nervous system involvement is caused by a spread of this neoplasm. It is not impossible for such a patient to have a subdural hematoma, or a brain abscess, or a spinal epidural abscess, or a benign slowly-growing intrinsic neoplasm of the brain which, if not recognized and treated, may lead to his demise long before the carcinoma or sarcoma itself has run its fatal course. These possibilities are mentioned not because they occur frequently, for indeed that is not the case, but rather to emphasize the fact that they can occur and that they should always be kept in mind and recognized if possible. Finally, the establishment in a given case that the lesion in the brain or cord is unquestionably secondary and metastatic should not without careful thought and exercise of judgment lead to a feeling of despair and an abandonment of all hope and treatment. The removal of a solitary metastatic nodule in the brain or the decompression of the spinal cord at the site of secondary invasion may not only serve in properly selected cases to relieve the patient of progressive distressing symptoms but may enable him to return for a brief span to a useful existence.

Summary

Only the general aspects of this question have been considered and no attempt has been made to embark upon details or to mention the many specific but less frequent afflictions that have to be taken into account. The presence of central nervous system tumors can be recognized more frequently and at an earlier date if one is constantly on the lookout for them. There are available rational and reliable techniques which when judiciously employed will in most instances establish the diagnosis. The histological character of the lesion can be estimated, and often correctly, before the operation, but in the final analysis the truth and frequently unexpected picture is revealed only at exploration. The presence of an expanding intracranial lesion should not in itself be looked upon as a harbinger of death. Many of these lesions, even when neoplastic in origin, are benign in character and can be successfully removed. In malignant lesions, palliation and prolongation of useful life can often be achieved. A brain abscess or a subdural hematoma may be discovered when a rapidly-growing and invasive neoplasm was anticipated. Surgical treatment should be considered in secondary tumors compressing the cord and in solitary metastases to the brain. In properly selected cases the outcome, though short-lived, is frequently a happy one and justifies the procedure.

* * * *

ERRORS IN DIAGNOSIS OF PULMONARY MALIGNANCY

Gustaf E. Lindskog, M.D.

I. The Neglect of Cough as an early Symptom.

The vast majority of cases in which a diagnosis of bronchiogenic carcinoma is finally made begin their course with an irritative nonproductive cough. This is due to the fact that about 70% of all bronchiogenic carcinoma are found to originate in the primary, proximal secondary or tertiary bronchi. At these levels, irritation of the mucosa provokes an active cough reflex, whereas in the more peripheral bronchi or parenchyma the reflex can not be evoked since bechic receptors are wanting. This early sign of cough is almost always labelled by the patient (and sometimes by his physician) a common cold, upper respiratory infection, bronchitis, or "cigarette" cough. So the operable early stages slip by, either because of understandable negligence on the part of the patient, against which only mass educational measures can avail to some extent, or because of less excusable temporizing on the part of the attending physician. Obviously, every patient who presents himself to his doctor with a recently acquired cough is not immediately a candidate for roentgenography or bronchoscopy because of the economic as well as the physical inconvenience. But a decision has to be made eventually. When a patient, 30 years or over, without obvious acute upper respiratory infection, begins to cough and is not completely relieved by simple measures after two or three weeks, he deserves a roentgenographic examination of the chest. If sputum is present, the tubercle bacillus must be ruled out by repeated examination. If not found, bronchoscopy is to be advised. Only by this approach can the operability in cases of bronchiogenic carcinoma be raised from the low level now obtaining.

II. The Presence of Tubercle Bacilli in the Sputum.

Not infrequently in the course of diagnostic procedures aimed at the elucidation of a supposed carcinoma of the lung, a concentrated sputum specimen may show a rare tubercle bacillus, or at least an acid-fast organism. This has occurred in our experience with tumors; with rapidly excavating lung abscess, and even in a case of bronchiectasis. Later developments or the excised specimens have ruled out tuberculosis as the primary etiology. It has been suggested that the progressive destruction of lung parenchyma by tumor, or sepsis, may invade latent foci of apparently healed tubercles and liberate a few bacilli. When the clinical history, physical and roentgen findings are heavily in favor of tumor, the finding of a single positive in a concentrated sputum should not weigh too heavily against the use of bronchoscopy or other diagnostic surgical procedures. Furthermore, the roentgenographic demonstration of calcified areas in a pulmonary infiltration or in the hilar lymph glands is not a pathognomonic sign of tuberculosis, since these may be present in malignant areas as well.

III. The Clinical Picture of Lung Abscess.

In about ten per cent of adult patients who present the clinical appearance of suppurative pneumonitis and lung abscess, later developments will demonstrate an underlying bronchiogenic carcinoma. The mechanisms by which this simulation is effected are of two sorts:

1. Focal bronchial obstruction, (as with foreign body or bronchostenosis), producing atelectasis, and suppuration because of secondary infection. These are the cases which may be difficult clinically to differentiate from ordinary abscess, and which make it essential to bronchoscope every case of lung abscess before surgical treatment at least once. In these cases we have found laminagraphic x-ray examination of great assistance before bronchoscopy.

2. Massive necrosis of widely infiltrated lung by interference with the blood supply, following which bronchiogenic infection supervenes. Usually these cases are clear as to the initial diagnosis from the history, secondary extensions (such as involved nodes, metastases or roentgen findings.) In the first group there may still be some hope for cure by pneumonectomy, whereas cautery drainage as usually carried out for abscess is simply palliative and leads to undesirable sequelae which may effectively prevent radical treatment later.

IV. "Benign" Appearance in the Roentgen Examination.

A well circumscribed, dense and presumably encapsulated mass in the lung fields is frequently considered to be a benign lesion such as dermoid cyst, fibroma, or encapsulated pleural fluid. We have been much impressed during the last two years by three such cases in which eventual operation or autopsy showed that the lesion was a true bronchiogenic carcinoma of epidermoid type, growing expansively in a centrifugal fashion with more compression than invasion of the surrounding lung.

V. "Benign" Appearances in the Bronchoscopic Examination.

A poorly defined group of bronchial tumors, called variously adenoma, mixed tumor, etc., are characterized by a smooth, well encapsulated presenting surface on endoscopic inspection. These cases frequently have histories which extend over periods of many years. Bronchoscopic removal by diathermy or excision has resulted in some long-term cures. Yet review of these cases indicates that many, if not all, are potentially or actually cancers, and should be treated by radical measures if the situation permits.

In these cases, as well as other types of carcinoma, the presence of an asthmatic wheeze may lead to erroneous diagnosis, by confusion with true allergic bronchospasm.

VI. Aspiration Biopsy.

A revival of enthusiasm for the use of needle biopsy in suspected lung tumor is beginning to be noted. This technic has two dangers:

1. The danger of pleural infection (empyema) when the lung is secondarily infected and the pleural surfaces not adherent.

2. The danger of misinterpreting negative biopsy reports. As previously stated, about 70% of bronchiogenic tumors are near the hilus. The physical and roentgen signs may be much more extensive than the tumor itself, due to secondary changes in the peripheral lobules of

the involved area, chiefly atelectasis and pneumonitis. The introduction of a needle into such peripheral areas results in no tissue diagnosis and an entirely false sense of security may develop therefrom. Needle biopsy should never be done until bronchoscopy has been tried and found wanting; even then, direct exploration is the procedure of choice in most cases.

VII. Peripheral Tumors Involving the Pleura and Simulating Pleurisy with Effusion or Localized Empyema.

Rapid involvement of the pleura from a previously silent peripheral carcinoma may result in severe and sudden pain, and rapid development of hydrothorax simulating tuberculous effusion. Since the effusion is sterile, and guinea pig inoculation a tedious procedure, fluid should be aspirated from, and pneumothorax induced on, the involved side. High speed centrifuging of the fluid followed by microscopic examination of the imbedded cellular sediment may reveal tumor cells. Roentgen examination may be successful in showing involved lung after removal of most of the fluid. Thoracoscopy performed when the pneumothorax has been sufficiently extended may reveal pleural implants of tumor which can be biopsied. These cases are not amenable to surgery.

A peripheral tumor may wall itself off as it invades the pleura in which case it simulates a localized effusion. In one of our cases we actually found pus in association with the tumor tissue. Severe and intractable pain is characteristic; the radiation of pain when the tumor is located in the apical pleura may simulate the pain of cervical rib, and other types of brachial neuritis.

* * * *

PROBLEMS AND ERRORS IN THE DIAGNOSIS AND TREATMENT OF RENAL TUMORS*

Clyde L. Deming, M.D.

Malignant tumors of the kidney exhibit outstanding characteristics which invite grave problems and induce errors in diagnosis and treatment. Ninety-five per cent of all renal tumors are malignant. They occur throughout the span of life; show a high degree of malignancy; develop silently into large tumors in 30 to 45 per cent of cases; and many times introduce themselves through their metastases. At present, only about 15 to 18 per cent of patients recover from malignant renal disease. The popular treatment is nephrectomy. The operative mortality is 12 per cent. About 10 per cent of patients refuse operation; 20 per cent are explored and the tumor found to be inoperable; and the rest, 43 per cent, die of metastases within a year or two. Twenty per cent of malignant renal tumors occur in children before the tenth year. The average age, however, is 64 years. Crabtree in Boston reports twelve malignant tumors in individuals over 80 years of age. The highest degree of malignancy is found in children and the lowest degree of malignancy, as would be suspected, in the oldest group. The type of malignant tumor can not always be ascertained before surgical exposure of the tumor and even then many times not until a histological study has been made. The embryonic cancers are seen through out life. Sarcomas are not confined to children, as was formerly thought. Hypernephromas and papillomas of the kidney pelvis are seen most frequently in the latter part of life.

The diagnosis of renal neoplasm may presumably be easy for the clinician who finds hematuria and a large visible and palpable tumor in the flank. Most cases, however, require complete urological study for accurate diagnosis. Some renal tumors are found accidentally at operation upon the kidney for other purposes, in other cases, the diagnosis is accredited to the pathologist at the post mortem table. The cardinal signs and symptoms, hematuria, tumor, and pain, should make one highly suspicious of a kidney tumor. The deformity or "filling defect" in the pyelogram clinches the diagnosis in a very high percentage of cases. Mimic tumors are found in polycystic kidneys; solitary cysts of the kidney; ovarian cysts, tubal pregnancy; splenic, hepatic, and pancreatic tumors; fecal tumors; psoas abscess; retroperitoneal tumors; lymph gland enlargements; suprarenal tumors; and large renal calculi. Tumors of the kidney pelvis, such as papillomata and squamous cell carcinoma, may not cause an enlargement of the kidney unless they obstruct the ureter, thus producing a hydronephrosis of varying degree. Palpation is not a dependable method of diagnosis. Polycystic kidneys are usually bilateral. The differentiation of hepatic and splenic tumors is not always easy by palpation. The differentiation of bowel tumors is usually accomplished by outlining the bowel with an opaque medium.

---

*From the Department of Surgery, Yale University, and the New Haven Hospital, New Haven, Connecticut.

Pyrexia is present in 18 to 20 per cent of renal tumor cases without an infection. Some writers have attributed pyrexia to metastatic lesions. Others have shown conclusively that the temperature sudsides with removal of the tumor. Thus to prognosticate a case by the fever is erroneous. The pyrexia has been attributed to the formation of specific pyogenic substances not necessarily in the presence of necrosis. Israel suggested that it was due to mixed renal tumor development.

Pain is a variable factor and is present in about 50 per cent of the cases. Pain is not due as much to the tumor as it is to the passage of blood clots down the ureter. If the tumor is growing rapidly and distends the renal capsule, the pain may be more or less constant and dull in character.

Hematuria is never present until the tumor has grown into the calyces or pelvis of the kidney. Hence a tumor growing upward from the upper pole or downward from the lower pole will not cause blood to appear in the urine until it becomes large and has replaced much of the kidney substance. Tumor cells are occasionally found in the urine when the tumor has broken into the pelvis of the kidney. Blood in the urine is a common finding in kidneys infected with pyogenic and tubercular organisms. About 20 per cent of cases of renal tumor are complicated by pyogenic infections, and one must be aware that the conditions may be coexistent. Most clinics report that 60 per cent of renal tumors cause hematuria.

Considerable interest has been shown in the demonstration of *hypertension* in renal tumor patients. This occurs in 50 per cent of the cases. When one realizes that 70 per cent of the patients are more than 50 years of age and that they may naturally have an elevated blood pressure reading, hypertension becomes less significant. Furthermore, the removal of the malignant kidney usually shows little effect on the blood pressure. However, a fluctuating blood pressure may suggest a suprarenal tumor or involvement of the suprarenal gland by extension of the primary tumor.

An accurate *diagnosis* of renal tumor is made by cystoscopy and retrograde pyelographic study. Pyelograms of both kidneys should always be demanded. An intravenous pyelographic series should rarely satisfy the physician. Considerable advantage is obtained by studying the urine and functional tests from each kidney, which, taken with the whole study, aid in determining the treatment. If a tumor is present, the plain x-ray film should show an abnormal outline of the kidney, a bulging of the periphery of the kidney in the tumor area. Sometimes a cone film is of distinct advantage in the fat individual. Some renal tumors show calcific deposits, which are considered to be indicative of a more favorable prognosis. Renal calculi and tumors do coexist. Some calculi are the result of tumor debris, especially in the cases of papillomata or squamous cell cancer of the pelvis. Errors in diagnosis occur in cases of non-opaque calculi and blood clots from ulcers and infection. A diagnosis of tumor was erroneously made in this clinic in the case of a woman with a complaint of renal pain and with a persistent defect in one of the calyces due to an infarct. Retroperitoneal and retrorenal tumors may displace the kidney and sometimes invade the kidney. However, in these cases the pelvis of the kidney is not deformed, and a lateral pyelogram will show a forward displacement of the kidney. It is rarely necessary to explore a kidney to determine the presence of a tumor. If there is any doubt, pyelograms repeated at intervals of two weeks will ususally reward the diagnostician. Dean suggests a needle biopsy for renal tumors. This seems hardly necessary except in cystic tumors. X-rays are valuable to elicit the condition of the second kidney. Spontaneous bilateral renal tumors do occur. It is also well to keep in mind that about one person in every 2500 is born with only one kidney. A malignant tumor occurring in a solitary kidney is rare, but the unusual many times appears when least expected.

The greatest problem is that of metastasis. Renal tumors are widely disseminated through the blood stream. The most common sites of metastasis are the bones, lungs, liver, and brain. Extension of adeno carcinomata into the regional lymph nodes is common. Hypernephromata not infrequently extend into the renal vein, vena cava, to the opposite kidney, or even to the heart. A pathological fracture of a long bone has been recorded several times as the first sign and symptom of the presence of the renal tumor. It is not infrequent to find metastatic lesions in the lungs during routine chest x-rays. Metastases to the brain sometimes exhibit their symptoms before any of the cardinal symptoms of the primary tumor manifest themselves. Hence, before any therapy for a renal tumor is prescribed, an x-ray of the lungs and perhaps of the long bones is advisable to determine whether or not metastatic lesions are present.

The treatment for renal tumors is nephrectomy, irradiation, or a combination of the two. Surgical removal of the tumorous kidney is the method of choice in most clinics when the tumor is not fixed and there are no metastatic lesions. When the tumor is relatively small, there is no particular difficulty in the surgical technique. When a large tumor exists, it is surrounded by large veins of collateral circulation, which cause considerable hemorrhage at operation. If extension into the renal veins or vena cava has occurred, the surgeon is justified in opening the cava and removing the tumor. The recovery of several patients so treated justifies this procedure. Whether these kidneys are approached via the lumbar incision or the transabdominal route depends upon the surgeon. The author prefers the lumbar approach in all cases. The problem of exposure is many times solved by a resection of the 12th rib and, in some instances, by resection of both 11th and 12th ribs. It is not only desirable but necessary to do a complete ureterectomy in cases with papillomas or papillary carcinomas of the kidney pelvis. If one has done a nephrectomy and later finds that the tumor is of this character, the surgeon should at a later date remove the remaining portion of the ureter, because there is a great likelihood of the existence or of the development of a metastatic lesion at the lower end of the ureter within a period of one year. If the tumor is found to be inoperable, one is justified in taking a biopsy and ligating the ureter to stop the hematuria. To control the hematuria in the inoperable cases in this way gives the patient psychological relief and prevents pain in the ureter from the passage of blood clots. Ligation of the ureter should not be done when the kidney contains an infection. A nephrectomy should be attempted in all cases in which there are no signs and symptoms of metastases.

The problem arises whether one should remove the kidney if there are demonstrable metastases. The answer is universally "no." One metastasis means that there are likely to be others. Bone and lung metastases are considered fatal. However, Barney and Churchill report an adenocarcinoma in a woman of 55 years who had a subtotal lobectomy for pulmonary metastasis fifteen months after the nephrectomy and who was living and well five years later. Bumpus reports one case and Beer reports two cases of pulmonary metastatic lesions from renal adenocarcinomata in which clinical and x-ray evidences showed complete spontaneous regression. We do not know what biological influences control local metastases or cause them to disappear.

The treatment of renal tumors by irradiation has advocates pro and con. Early reports stated that radiation produced but few changes in the tumor cells. Consequently, x-ray therapy was more or less discredited. Waters claimed that hypernephromas and embryonal carcinomas were radiosensitive. To these classes has been added Wilm's tumors by NcNeil of New York. Certainly, adenocarcinomas and papillary carcinomas of the kidney pelvis show little response to present-day radiation therapy. Munger states that supervoltage x-ray has proven no more embarrassing to normal kidney structures than irradiation with voltage of less intensity. Experimental irradiation of normal kidneys does not support this fact. One finds the recent literature containing articles urging preoperative radiation. Some authors recommend treatment with massive doses; others, with fractional doses. The relative value of these methods is not clear. Probably much depends on the sensitivity of the tumor, the age of the patient, and whether the tumor is located in the right or left kidney. Heavy radiation of the right kidney in the presence of a long, overlapping, right lobe of the liver causes severe hepatic damage. In general, radiation of 3000 to 4000 hours causes the tumor to shrink considerably. Even small doses of 400 to 500 hours, in the case of a child of 5 years, caused a regression of a large embryonal renal cancer to a normal-sized renal shadow. Multiple metastatic lesions of the chest in this patient likewise responded to relatively small doses, but the lesions promptly returned There is no doubt that irradiation does reduce the size of the large collateral vessels and makes operative procedure less bloody. When there is reduction in the size of the large tumor, removal of the tumor is less hazardous.

Postoperative radiation has been strongly advocated by continental schools. This is logical, because the results of all forms of treatment have been discouraging. Since only 16 to 20 per cent of patients are cured by nephrectomy, we feel like grasping for any additional therapy which will improve this figure. No figures are available to show the results of preoperative radiation at the end of a five or eight-year period. The preoperative determination of the sensitivity of a tumor to irradiation would seem logical; but Dean thinks that the danger of spreading the disease by needle biopsy is too great in comparison to the value of the procedure. Much care should be exercised in palpation of renal tumors and in handling the renal tumors at operation, in order to prevent squeezing out the tumor cells and causing metastases. Certainly it is logical to expect that preoperative radiation may devitalize the tumor cells to some extent and make spreading of the cancer at operation less likely. If, after operation, there remain a few cancer cells which can be controlled by radiation, it may well be applied. Since about 45 per cent of the patients die the first year after operation due to metastases, it is very possible that some of these metastatic lesions might be controlled by postoperative radiation.

In order to solve the many problems in the diagnosis and treatment of tumors, we must urge immediate investigation of all cases of hematuria, because all cases of hematuria are due to malignancy until the presence of tumor is ruled out by cystoscopic and x-ray examinations. A physician commits a grave error in prescribing a so-called styptic for patients with hematuria unless he is fully conscious of the pathology giving rise to the blood in the urine. An accurate diagnosis by complete urological study should be made in all cases in which the patient suffers with pain in the back and in all cases of abdominal tumor. Biopsy should be made of all metastatic lesions whereever feasible. Preoperative and postoperative irradiation would seem plausible. Surgery alone is at present adequate for only a very small group of cases. The treatment of renal tumors is a combined problem for the urologist and the roentgenologist.

REFERENCES

1. Barney, J. Dellinger, and Churchill, Edward D.: Adenocarcinoma of the kidney with metastasis to the lung. Transactions of the American Association of Genito-Urinary Surgeons, 71-79, 1938.

2. Beer, Edwin: Some aspects of malignant tumors of the kidney. Surg., Gynec. and Obst., 65: 433-446, 1937.

3. Bumpus, Hermon C.: The apparent disappearance of pulmonary metastasis in a case of hypernephroma following nephrectomy. Jour. Urol., 20: 185-191, 1928.

4. Crabtree, E.G.: personal communication.

5. Creevy, C.D.: Pyrexia in malignant nephroma (hypernephroma). Jour. A.M.A., 92: 1256-1260, 1929.

6. Dean, Archie, L., Jr., and Pack, George T.: Embryonal adenosarcoma of the kidney. Jour. A.M.A., 98: 10-17, 1932.

7. Israel, J.: Ueber einige neue Erfahrungen auf dem Gebiete der Nieren Chirurgie. Deutsche med. Wchnschr., 22: 345, 1896.

— and Israel, W.: Chirurgie der Niere und des Harnleiters. Leipzig, 1925, p. 436.

8. McNeill, Walter H., Jr., and Chilko, Alexander J.: Status of surgical and irradiation treatment of Wilms' tumor and report of two cases. Jour. Urol., 39: 287-301, 1938.

9. Munger, Arbor D.: Irradiation of malignant renal neoplasms. Jour. Urol., 37: 680-691, 1937.

10. Waters, Charles A. Preoperative irradiation of cortical renal tumors. American Jour. Roentgenology and Radium Therapy, 33: 149-162, 1935.

11. Wharton, Lawrence R.: Preoperative irradiation of massive tumors of the kidney. Archives of Surgery, 30: 35-51, 1935.

* * * *

PROBLEMS AND ERRORS IN THE DIAGNOSIS OF CANCER OF THE UTERUS*

Arthur H. Morse, M.D.

In surveying the histories of patients hospitalized for cancer of the uterus during the past five years one is struck by the extent of the lesion which each patient presented upon admission. Such a finding is not peculiar to our community, for similar conditions exist in other localities. For example, Foss, detailing his experiences in a hospital catering to a rural population, states that the patient of this group who suffers from cancer tends to resort to home remedies and to bizarre forms of self-medication, a situation for which he indicates the physician is frequently responsible. Although the woman with vaginal bleeding is aware of something unusual, she at first attaches no particular significance to it. Four or five months later she consults her family physician, a busy country practitioner, who perhaps prescribes ergot but makes no pelvic examination. He does not see her again for six months. "In the interim", continues Foss, "in addition to the prescribed treatment, she tries a dozen or more home remedies recommended by relatives or friends and may resort to a multitude of bucolic therapeutic vagaries practised in her neighborhood. Finally, if she is examined by a competent physician, the lesion is recognized, but only after the disease has become so advanced as to make treatment hopeless."

---

*From the Department of Obstetrics and Gynecology, Yale University School of Medicine.

Cooke, of Texas in a second paper, states that in spite of all that has been written and said concerning the prophylaxis and early diagnosis of cancer of the cervix, the status of most patients referred for treatment is as bad as it was many years ago. He believes that owing to the publicity given to the subject most women are informed of the suggestive symptoms of cervical cancer and ask for examination promptly upon the appearance of symptoms. Cooke then offers a caustic criticism of the medical profession in the following words: — "The incredible apathy of the profession at large toward prophylaxis, and the quite simple technique of the recognition of early cancer of the cervix, have resulted in a general failure to accord the patient the adequate examination which she deserves." "In other words," he concludes, "it is now the fault of the profession at large that the incidence and mortality rates of cancer of the cervix show little improvement,"

The communications just quoted raise several points which may be examined in the light of our own experience. A survey of the cases of uterine malignancy admitted to this hospital since 1935 leads one to doubt seriously whether women in general recognize abnormal discharge or bleeding as an evidence of possible cancer. Too, often because they are accustomed to vaginal discharges or to irregularities of menstruation, they place little importance upon these occurrences unless there is active continued bleeding or the discharge of clots. The delay in the first visit to the physician is more readily understandable in the case of women who are approaching but have not yet passed the menopause. Under such circumstances the symptoms may be attributed to the "change of life", or the medical consultation may be delayed as the reuslt of advice given by older women now in good health who state that they themselves previously had similar symptoms. If only the early developing cancer and the discharge or bleeding from the lesion were accompanied by pain comparable to that felt in a decaying tooth the problem would be simplified. At present, however, we usually find upon the patient's admission to a hospital that malignancy of the cervix is so advanced as to be almost certainly recognizable at sight.

Less readily understood is the failure to attach significance to bleeding or discharge which begins several years past the menopause. One would assume that the recurrence of bleeding, subsequent to a complete freedom from discharge over an interval of months or years, would prove of significance to the patient or to her relatives, but too frequently the symptom is disregarded. For example, in a series of patients with fundal cancer, all of whom were several years past the menopause, two came for advice a year and a half following the onset of symptoms, another at the interval of a year, a fourth after irregular bleeding throughout a period of fifteen months, and a fifth after an interval of five months. Such information indicates that in this community a certain percentage of women pay little attention to vaginal bleeding or, if they are disturbed by it, nevertheless delay for a considerable period before seeking a medical opinion respecting the origin of the symptom.

On the other hand, vaginal discharge and bleeding as evidences of early cancer of the cervix may be illusory, and in no sense indicative of the character or extent of the lesion. The following examples illustrate this point:

1. A woman 38 years of age entered the wards in May, 1939. A housekeeper who was constantly on her feet, she stated positively that

she had been well up to Apr. 11, 1939. During the second day of what she had regarded as a normal menstrual flow she began to bleed profusely, and this loss of blood continued for three days. On the 30th of April she began to bleed again and this continued up to the day of admission, May 2, 1939. Two weeks elapsed from the onset of the bleeding to the first visit to her physician and three days later she entered the hospital. Examination revealed a fixed cervix almost completely destroyed by an ulcerating cancer which was extending laterally to the pelvic walls.

2. A woman of 53 whose menopause occurred in 1935 had had no discharge or bleeding during the past 5 years. The first slight vaginal bleeding was noticed subsequent to a fall 7 weeks prior to admission. Upon examination the infravaginal portion of the cervix was found replaced by a friable irregular cancerous mass.

3. A woman of 63, who reached the menopause at 51, stated that she had been well up to Sept. 21, 1938, the day of the hurricane, when she waded through deep water. Five days later bleeding began, associated with discharge of clots. She entered the wards Nov. 14, 1938, at which time there was found an anaplastic epidermoid carcinoma of the uterus with vaginal metastases.

4. A woman 26 years of age complained of the onset of intermenstrual spotting about six weeks before admission. Examination showed Grade II squamous cell cancer, a nodular growth involving the entire infra-vaginal portion of the cervix.

5. A woman 45 years of age, was certain that there were no abnormal symptoms until 6 weeks prior to admission when she noted irregular and intermittent bleeding which seemed to be a continuation of her menstrual period. Three weeks before admission she began to have a foul discharge. Upon examination the cervix was found occupied by a firm friable carcinomatous mass extending into the posterior fornix and the base of the right broad ligament.

Four of the patients just mentioned entered the hospital from five to seven weeks from the time vaginal bleeding first attracted their attention; in the case of the fifth patient there was a delay of only two weeks. In each instance, however, examination revealed a well-advanced carcinoma of the cervix. This experience makes it clear that even though patients come for medical advice within a relatively short time after the onset of symptoms, it does not necessarily follow that the cervical growth will still be in an early stage of development. To put it more exactly, if ever we are to see the early stages of cervical malignancy we must cease relying upon what are designated as the first signs of cancer, but must emphasize the necessity of a routine yearly, or better semi-yearly, examination of the pelvic organs, even though no symptoms are present. As you know, such a plan is already under way in this State through the initiative of Doctor Charles Larkin. This is a step in the right direction and the plan, if widely adopted, would without question salvage the lives of many women who at present are seen only when the malignant lesion has reached an advanced stage.

You will recall that a statement quoted in an earlier paragraph intimated that some members of the profession itself are apathetic respecting the diagnosis of cancer of the uterus. It is with some hesitation that I enter now upon a discussion of this point, and I hope that my remarks will not be misunderstood. The information at my disposal is derived in some instances from statements made by the patient upon admission, and these statements, of course, may lack complete accuracy. From a survey of a group of histories, however, it is clear that there are some members of the profession who wholly disregard the possible significance of abnormal uterine bleeding or who fail to suspect malignancy even when it is present. In ten patients whose histories were reviewed, vaginal bleeding in some instances profuse, was the sole cause of the visit to the physician. However, it appears that no pelvic examination was made in any of these cases. Some women were given a drug by mouth or vaginal douches were prescribed. Others were told that the bleeding was of no significance. One patient with cancer of the fundus had been treated with tampons and douches; another with the same lesion and 66 years of age was told that she had uterine myomata; a third sent into the wards for a repair of the perineum harbored a fungating cancer of the cervix; a fourth, who had had irregular bleeding and cervical discharge for eight months, was thought to have had uterine myomata for which she was treated by x-radiation. Since there was no cessation of bleeding the patient saw another physician who advised hospitalization, when a cancer of the cervix was found.

Four patients had already undergone a minor or major operation previous to admission for continued bleeding: —

1. One consulted her physician because of bleeding following intercourse. She was hospitalized and the cervix was cauterized. The cervical bleeding continued and she was finally admitted with a cervical cancer, Grade II.
2. The second patient first noticed intermenstrual bleeding in November, 1933. She consulted her physician in February, 1934, and what appears to have been a cervical repair was done. The bleeding ceased for five months and then recurred with increasing vigor. Biopsy twenty months after the appearance of the first symptom disclosed cervical cancer.
3. The third patient, who twenty-five years after an uncomplicated menopause had a recurrence of bleeding, was treated over twelve months for a urethral caruncle. Four weeks before admission two cervical polyps were excised. A curettage revealed a cylindrical cell cancer of the uterine body.
4. The last of the group, a woman of 54 complained of vaginal bleeding in June, 1937, for which a supravaginal hysterectomy was performed. Since bleeding continued, the cervix was excised in August. In October she entered the wards with a rapidly growing squamous cell cancer of the cervix.

The comments just recorded make at best a bad showing, but they indicate outstanding problems in the diagnosis and treatment of pelvic cancer. Such errors in diagnosis and treatment generally arise in two ways: either the examiner fails to recognize the presence of a lesion or, recognizing its presence, he fails to interpret its true character. Both types of error are presented in the cases mentioned. If in the first group of patients the attendant had taken the trouble to make a pelvic examination, it is reasonable to suppose that he would have realized that some abnormal condition of the cervix existed, and quite likely in a certain percentage of cases he could have made at least a tentative diagnosis of malignancy and referred the patient to the sources of proper treatment. This perhaps is as much as we should ask at present from the physician beset upon from all sides by the demands of general practice. Nevertheless, if the general practitioner can be brought to realize that the presence of abnormal discharge or bleeding from the vagina makes a pelvic examination imperative, it will be a great step forward. In the second group of patients treated by some operative procedure the attendant recognized the presence of a lesion, but apparently no attempt was made to determine its character before selecting the type of treatment carried out in the particular case.

In conclusion, an analysis of the histories of this limited number of patients brings out certain facts which may be summarized as follows: —

Many women persist in attaching little significance to abnormal uterine bleeding as evidence of cervical malignancy, and present themselves for examination only when the growth has reached an advanced stage. Others who come for examination within a reasonable interval from the onset of the symptom harbor extensive lesions notably disproportionate to the limited severity or duration of the associated symptoms. Therefore, to advise women to depend solely upon uterine hemorrhage or discharge as early evidences of malignancy of the cervix is misleading and surrounds them with a false sense of security. Moreover, even though present in certain of the cases in question, the importance of the symptoms was passed over by some practitioners without raising the suspicion of malignancy. As a result either improper therapeutic measures were advised or there were performed operations generally unacceptable as correct methods of procedure in the current treatment of uterine malignancy.

Finally, as an aid in solving the problems in question, the Blue Book on Cancer recently published by the State Department of Health should be most helpful. Written clearly and concisely and containing invaluable information it reflects great credit upon its numerous contributors and upon its Editorial Board. Study of this manual should stimulate an increasing awareness of malignancy and of greater importance, should incite practitioners to make still more conscientious and accurate diagnostic observations in this field of medicine.

REFERENCES

Cooke, W.R.: Prophylaxis and treatment of carcinoma of the cervix and body of the uterus. Surgery, Gynecology and Obstetrics, 1940: 70, 500. February 15.

Foss, H. L.: Cancer control in the rural sections. Editorial — Surgery, Gynecology and Obstetrics, 1939: 69, 380. September.

* * * *

CARCINOMA OF THE STOMACH

John C. Leonard, M.D.*

Doctor Oughterson has asked me to discuss the problem of diagnosing carcinoma of the stomach from a medical viewpoint.

Unfortunately there is no characteristic clinical picture in early carcinoma of the stomach, so that by the time the physician or the clinic may have a right to be suspicious of the diagnosis, the case is usually one of far advanced cancer of the stomach.

Anorexia or indigestion consisting in mild epigastric discomfort or fulness after meals may be among the earliest recognizable symptoms. To these symptoms the patient is likely to give very little serious early thought and even his physician, if consulted, may feel that this is just a temporary gastric upset to be treated palliatively. Not until much later in the course of the disease is the patient likely to present such signs and symptoms as anemia, weight loss, upper abdominal pain, palpable tumor, nausea, vomiting, dysphagia and hematemesis. By the time this group of symptoms has put in appearance the patient is almost certain to be hopelessly advanced in his disease.

How can we then hope to pick up the early case so that surgical cure may be effected? This can only be approached by the maintenance, on the part of the physician, of a high index of cancer suspicion in dealing with digestive arrhythmia especially in patients above the age of 40 years.

Obviously we cannot provide a gastro-intestinal x-ray series for every patient who has gastro-intestinal complaints, even though we realize full well that cancer of the stomach is largely an x-ray diagnosis at the present time. We do make it a rule, however, to do a careful analysis of the gastric contents and a study of the stools for the presence of occult blood in every patient above the age of 40 years who has gastro-intestinal complaints, and also for younger patients who have unusual gastro-intestinal symptoms.

Gastric analysis has been a much neglected procedure. We do realize that an occasional case of cancer of the stomach is found when the gastric analysis shows hyper chlorhydria and that many old people have achlorhydria without having cancer of the stomach, but the great majority of our cases of carcinoma of the stomach have complete achlorhydria after histamine stimulation, or at least have marked hypochlorhydria.

Histamine stimulation (histamine injected subcutaneously) has been criticised as being unphysiologic, but a true achlorhydria cannot be said to exist unless histamine is used. When histamine was used in 1 mgm. doses, reactions (headache, flushing and palpitation) were frequent. In the past three years, in our clinic, we have used only doses of 0.5 mgm. of histamine and have had infrequent reactions with this dosage. Histamine is not used in patients who might suffer harm from a possible reaction. In these patients 50 c.c. of 7 per cent alcohol is used as a test meal.

The Guaiac test for occult blood in the stool is a simple test, easily and quickly performed, and should be done in any and all patients with gastro-intestinal symptoms. If the test be positive (in the absence of hemorrhoids) it is very helpful. Unfortunately it is not a very sensitive test and, therefore, many patients with carcinoma of the stomach may have a negative stool guaiac test unless the test is performed repeatedly. The Benzidine test for occult blood in the stools is much too sensitive for practical routine use, since it is necessary to keep the patient on a meat free diet for two to three days in order to avoid a false positive test. A test for occult blood, intermediate in sensitivity between the Guaiac and Benzidine tests, would be very helpful.

The expense of x-ray examination of the stomach has been another important factor in preventing the early diagnosis of cancer of the stomach. If gastric analysis and a study of the stools for occult blood are done more routinely, they will serve as an important guidepost in pointing out the cases who are most urgently in need of a careful x-ray study of the gastro-intestinal tract.

---

*Physician-in-Charge, New Haven Hospital Medical Dispensary.

In closing, I wish to make a plea for more careful gastric study in that large group of cases whose gastro-intestinal symptoms are thought to be on an emotional basis. This group comprises the majority of the patients with gastro-intestinal complaints seen in our clinic. It is all too easy to take this for granted and these patients, as a result, are likely to be shuttled back and forth from clinic to clinic. It is well to bear in mind that a patient who is a "Psychopathic Personality" may still have a cancer of the stomach!

* * * *

GENERAL DISCUSSION

Doctor Clyde L. Deming

As urologists, we have been asked to see certain cases of cancer of the cervix and fundus of the uterus, and I would like to ask Doctor Morse to tell us what involvement of the bladder signfies and how it effects treatment. What is your reaction when you are given a report from us on a case stating that the bladder is involved?

Doctor Arthur Morse

Extension of cervical cancer to the bladder complicates an already serious condition. If the base of the bladder is involved it is usually very unwise to make use of radium, but in some cases Doctor Wilson has given deep x-ray therapy. If radium is used when the bladder is involved, a vesico-vaginal fistula is likely to result, making the condition of the patient more wretched than previously.

Doctor Deming

About what percentage of cases of cancer of the cervix do you ask us to see? What proportion of these cases do you usually have cystoscoped?

Doctor Morse

We have all of these cases cystoscoped, and in my opinion it is a very necessary procedure if these patients are to be properly treated.

Doctor William Stone, Norwalk.

I am sure that the propaganda that has been instituted by this Association of Tumor Clinics has resulted in educating the general practitioner in regard to cervical cancer. I have found in the past five years a considerable number of early cases of cancer of the cervix, and previously it was a rarity to see an early cervical cancer. But there is one instance in which I think the surgeons are still showing a considerable amount of carelessness and that is that too few of them perform a dilatation and curettage of the uterine cavity before they do a suprapubic hysterectomy for uterine myomata. A certain percentage of these cases of uterine myomata harbor cancer of the fundus at the same time. A curettage will reveal the presence of these cancers and radium can be inserted immediately, and after waiting six weeks to two months a panhysterectomy may be performed. With this treatment, the proportion of cures will be increased by about 40 per cent.

Doctor Thomas Russell, New Haven.

I would like to ask what procedure Doctor Morse follows when he finds on curetting a uterus not only a cancer of the fundus but also a pyometra. Will it be safe to give these women radium therapy? I have gone ahead in four of these cases and given radium treatment and no acute infection has resulted. One of these women was 78 years old.

Doctor Morse

I fear that there would be a risk involved when radium is used in the presence of pyometra. It probably would be safer to drain the uterine cavity and insert the radium at a later date.

Doctor Charles L. Larkin, Waterbury.

The insertion of radium in the presence of a chronic inflammatory condition is liable to result in an exacerbation of the inflammation, but the pyometra that is usually present in these elderly people is a gangrenous condition that results from poorly nourished, advanced cancer, and it is not comparable to the acute and chronic inflammation of the adnexa that is so often present in younger women. I have used radium in these elderly cases even when they have been running a temperature as high as 104 and 105 and have never had any untoward results. It is usually the only way to clear up the pyometra in elderly people and at the same time the cancer is being destroyed. If at a later date a hysterectomy is to be performed, it might be well to leave a small stump of the cervix rather than perform a complete panhysterectomy, because there is a definite increase in operative mortality following a panhysterectomy in these elderly patients that have complicating pyometra and have been radiated.

Doctor A. E. Laszlo, Bridgeport.

I am inclined to believe that in younger patients you are apt to get secondary infection following radiation but in older patients you are dealing with a more or less chronic process, and radium therapy does not cause such a severe reaction.

Doctor Russell

I have seen more cases of pyometra occur before radium therapy than after it, but it does happen occasionally afterwards, especially when contraction of the cervical canal with poor drainage occurs.

Doctor Oughterson

Doctor Stone has mentioned the fact that the propaganda instituted by this organization has resulted in the finding of more cases of early cancer of the cervix. How many men in this audience believe that our educational program in this state is comprehensive enough? (There was no show of hands.) How many are of the opinion that our educational program should be enlarged upon? (An unanimous show of hands.)

Doctor Stone

Our educational program probaby is not comprehensive enough but it has already had some good results and especially in finding early cancer of the cervix, but there is undoubtedly room for improvement in regard to instruction on other forms of cancer, particularly that of the rectum. The failure of doctors to find more early cancers of the rectum is lamentable. Most of these cases are still coming into our hands in a very advanced stage.

Doctor Larkin

Undoubedtedly there is room for improvement in our cancer education of the doctors and also of the lay people, but the question is what should your educational propaganda consist of? Certainly it should not be the same as some that is being peddled out by most cancer groups, which emphasizes the need of men and women reporting to their family physicians as soon as they notice unusual lumps or unusual discharges, or the presence of pain. This type of propaganda gives the people an idea that they can wait until these symptoms appear before they have to submit themselves to their physician, and if they do submit themselves for examination after these symptoms have developed, they will be in plenty of time and the cancers will be early ones. Unfortunately, when such symptoms appear it means that the cancer is no longer early and if the patients wait for these symptoms they will be jeopardizing their lives. There is only one propaganda that will be of any benefit towards finding cancers in the earlier stages than they are now and that is by the annual physical examination. People must be taught that early cancer does not give symptoms of any sort and these early cancers can only be found by competent physicians making routine annual physical examination.

Doctor Edward W. Foster, Meriden

It has been found that education of the physician has been successful to a certain extent but that education of the layman has not had the response which was expected as far as getting patients with cancer to come to clinic early. At the Meriden Hospital we have been able to get a large attendance of doctors to our regular Cancer Clinic. Out of a staff of approximately thirty we have usually about twenty-five attending, and have been able to get some results, we think, in the education of the doctors in cancer. Without being able to quote actual statistics, our definite feeling is that we are getting more patients to come in earlier.

Doctor Laszlo

I feel otherwise: that the public is better educated than the doctors. Even amongst the younger men, it is unusual to find a man who will not hesitate to put on a rubber finger cot and examine the rectum during a routine physical examination, or look at the cervix and vagina through a speculum. It is only by doing this that one can find an early cancer.

There is another thing to be considered and that is the prevalence of cancerphobia in patients. Often it is necessary to spend much time persuading a patient that he has not got cancer, and if a doctor is eternally looking for a cancer it will not help this situation. It would be better in my mind to have district clinics where patients can go without symptoms and ask for a physical examination, and have it done by men who are especially instructed in what to look for. There are many things that will be missed when the examination is made in the doctor's office and many examinations cannot be properly performed there. Often it is necessary to do blood counts and urinalyses and take x-rays which cannot be accomplished in a doctor's office. Therefore, if this examination is to be of the best it should be done in an institution.

* * * *

Doctor Oughterson's paper on "Problems and Errors in Diagnosis of Tumors of the Gastro-Intestinal Tract" was given a second time at the meeting of the State Medical Society and published in the Journal under that meeting.

Doctor Douglas J. Roberts, Hartford.

There are two sides to the economic question that Doctor Oughterson has raised, one that applies in the hospital and the other that applies more to the practitioner outside of the hospital. Doctor Leonard covered thoroughly when to order gastrointestinal examinations from a ward and out-patient standpoint, stressing the question of expense to the patient and to the hospital, but when one considers the private, especially the semi-private group of patients, I believe that here is a place where a public health type of x-ray service may be extended. This has already been tried out in chest examinations for tuberculosis in the nature of an exclusion type of film. The expense to the patient and to the radiologist is low and the service rendered to the internist is unquestionably of help in excluding tuberculosis. This is about all that it does and so far it is reported that it is being found useful and is not abused.

Malignancy of the stomach or colon may be diagnosed on an exclusion basis and likewise this service may be of definite assistance, especially for this particular economic group which can afford to defray only a limited amount. Naturally no single film can exclude malignancy in these parts but a limited barium meal or barium enema study with a limited charge would tend to exclude the vast majority of gastric or colonic malignant neoplasms and would probably indicate usually when a more meticulous roentgen study was necessary.

There is one other symptom of cancer of the stomach which may be added to your list and that is the onset of a fetid breath where none had existed before. We recently had such a patient referred to us for roentgen study of the stomach where the clinician had become suspicious of a malignancy based almost entirely upon this one symptom, he having had a similar case some years before which was the result of gastric cancer. This patient likewise manifested a rather extensive malignancy in the so-called "silent area" well upward in the cardiac end of the stomach.

Doctor Hugh Wilson, New Haven

I agree with all Doctor Leonard's statements. During the last five years we have been impressed with the importance of carrying out a complete x-ray examination including barium enema on all patients suspected of harboring cancer of stomach or colon. Even when one lesion is found, a second lesion may be demonstrated by completing the x-ray examination. As a result of the careful routine medical work-up outlined by Doctor Leonard we have been able to carry out more satisfactory gastro-intestinal examinations resulting in a high incidence of organic disease. About 70-80% of the cases referred by Doctor Leonard's clinic reveal positive x-ray findings. I believe this experience confirms the value of his medical work-up.

THE CONNECTICUT STATE TUMOR PROGRAM

HERBERT F. HIRSCHE,
Hartford, Conn.

To describe in detail the various ramifications of the Connecticut State Tumor Program would take too long in the limited time assigned me, hence I shall take the liberty of generalizing my remarks rather than confining them entirely to statistical phases of the subject. To do so it will be necessary to go back a few years and review the early beginnings of the cancer control movement in Connecticut.

Many of you are familiar with the fact that the first concerted attempt to organize a cancer control program within this state was undertaken some ten years ago by a few public-spirited citizens in New Haven. This consisted of a committee known as the Cancer Control Committee of New Haven with Mr. George Berger as the original chairman and twenty-six members representing both lay and professional groups. The primary object of this committee was to collect adequate mortality statistics relating to the disease and at the same time disseminate educational information to the general public. Later, when the program became well established it was recognized that some yardstick would have to be devised to gauge the effectiveness of the work already accomplished if the committee were not to remain in the dark as to its potential significance. To do so it became necessary to determine how long on the average patients delayed treatment prior to the inception of the program, and whether such delay was being reduced after a reasonable period of educational stimulus. To obtain such data hospital case histories had to be consulted, and this step immediately brought the committee in direct contact with certain of the clinical phases of the problem.

It must be recognized that ten years ago there existed a general air of apathy regarding the cancer problem throughout the state. Hospitals, except in a few isolated instances, made little or no attempt to follow their cancer cases, clinics were practically non-existent and no such organization as the Tumor Committee had as yet appeared on the horizon. Due to the fact that little concerted effort was being made to determine the post-hospital status of cancer patients, the committee felt that here was an opportunity to rectify a deplorable situation. Accordingly a central clearing house was organized wherein death certificates and city directories could be consulted and compared with hospital admissions. The results were most gratifying, for during a ten-year period only three per cent of the cases admitted to hospitals in New Haven remained untraced. This demonstrated conclusively that a centralized agency could be of inestimable value in following patients for hospitals and private practitioners. Furthermore, such an agency would be in a position to statistically analyze much cancer material if this were deemed advisable.

It was, as you are well aware, during the year 1935 that the State Medical Society in cooperation with a few public-spirited citizens persuaded the Legislature to appropriate funds for a state cancer control program. With the advent of this appropriation the status of things changed for it now became necessary to revamp a small localized experimental program into one of state-wide proportions.

It should be recognized that in making this change a number of problems had to be carefully worked out. In the first place the State Department of Health had to organize an entirely new division in conformance with legislative action. Secondly, it was necessary to devise certain administrative procedures likely in the end to improve the cancer situation and at the same time maintain a mathematical check on such activities. To set this machinery in operation required a fine sense of coordination between the State Tumor Committee on the one hand and the State Department of Health on the other. Incidentally this necessary form of coordination might never have crystallized had it not been for the calibre of men representing the Tumor Committee — men in this instance who have always been able to see both sides of a question.

In planning a well-rounded cancer control program there are at least three major activities which must be engaged in. These consist of the education of the general public in the symptomatology of the disease, the creation of adequate facilities for diagnosis and treatment, and statistical analysis of morbidity and mortality. With the advent of the state program the second of these activities, namely, the creation of adequate facilities for diagnosis and treatment had already engaged the attention of the Tumor Committee with the result that a number of cancer clinics were already in operation. In regard to the other two phases of the problem, however, practically nothing had been done and we were therefore confronted with a virgin field of considerable magnitude. Time does not permit of a detailed discussion of these activities other than to say that although much remains to be done, there is no reason to be ashamed of what has already been accomplished. Quantitatively about 250,000 pamphlets, along with other forms of propaganda, have been distributed throughout the state and some 40,000 cancer death certificates reviewed and statistically analyzed. Thus again a centralized bureau of information has been developed within the State Department of Health similar to that in New Haven.

Unfortunately it is well recognized that the tabulation of cancer mortality data is not only subject to error, but does not give a clear picture of the magnitude of the problem within the general population. Furthermore, such figures cannot reveal the underlying social, economic and medical problems that beset the cancer patient. One must come closer to the patient than his death certificate to obtain such material. It is precisely for this reason that a scheme has been developed which constitutes one of the main objectives of the program, namely, the statistical analysis of cancer case histories obtained from hospitals throughout the State.

The adoption of such a plan on a state-wide basis is by no means an easy matter. In the first place if one is to obtain comparable data it must be obtained from comparable sources. This necessitated the designing of standard record forms adaptable for the purpose in view and yet not too complex to tax the resources of the smaller hospitals. Credit is due to the Record Committee for not only designing such a form but selling the idea of its adoption to twenty of our general hospitals. Having accomplished this much it then became necessary to create a comprehensive code covering the data contained on these histories so that ultimately the material might be punched on cards and sorted by mechanical means. Those of you who have attempted to design an airtight code, where a single mistake may cost considerable money, will recognize the inherent difficulties encountered. If it had not been for the assistance of the Committees on Pathology, Radiology and Records the problem might well have been insurmountable. It should be duly recorded that the Committee on Pathology alone and unassisted devised a topographical and etiological classification of neoplasms that bids fair to become an outstanding scientific contribution. Confidentially it not only looks impressive but actually works, except in these instances where some pathologist uses a fifty cent word for a five cent lesion!

From an administrative standpoint the adoption of this scheme was also beset by numerous difficulties. The question immediately arose as to how such data, widely scattered throughout the state, could be assembled and tabulated. Obviously the easiest way would have been for the various hospitals to send copies of their records to the central office, but this would have necessitated for them some expense and additional work. To obviate this a method was accordingly devised whereby the records could be photographed by means of a portable camera especially designed for this purpose. This machine incidentally is quite a contraption for it takes eight hundred pictures of about the size of a postage stamp on a single roll of film.

This system briefly described is now in operation. To date the records of the 1938 admissions to nine of our hospitals have been photographed and duly recorded. It is hoped that the analysis will be extended to include a number of other hospitals before the books are closed on the 1938 admissions. Obviously there is little that can be said about the results of tabulation at this early date. It can be pointed out, however, that the sample of material thus far studied is fairly large — consisting of 1,341 patients of which two hundred are breast cancers. It looks, therefore, as if with the passage of time a sufficiently large sample of material can be assembled which should be of statistical significance. Furthermore, with the backing of some 40,000 cancer death certificates the problem of follow-up should be materially lessened.

We have been specifically asked to criticize the way in which the hospital records are being filled out. As one might expect, with the diversity of material on hand, one finds many records superbly handled while others are far less adequate. Sometimes one finds a "gem" which can be compared to the replies given on a health survey conducted in Damascus many years ago. To the question "what is your birth rate?" came the reply "I hesitate to inquire." "What is your death rate?" was answered "all must die sometime, some die young and some late." In regard to the sanitary quality of the water supply came the rejoinder, "from time immemorial no one has died of thirst in Damascus." The comparison is perhaps odious but these replies are quite comparable to some of the answers given as to why the patient delays treatment or seeks clinic admission. The fault lies perhaps with the overworked interne who is apt to be so steeped in medical terminology that he becomes oblivious to the patient's sociological problems. However, apart from this and certain other minor criticisms it is evident that in most hospitals an honest attempt is being made to record adequate data.

We have attempted in a superficial manner to indicate certain of the administrative phases of our present state tumor program. This constitutes a courageous experiment the significance of which no one as yet can measure. Success if it comes will only come with the aid of the element of time. In this one factor lies both our strength and our weakness, for if we cannot continue to convince our legislators that the control of cancer must inevitably be a long term proposition, we may lose their confidence in this undertaking.

☆☆

THE MEDICAL PROFESSION AND THE FTC

"For many years the columns of the American Medical Association have been thundering away at quackery and nostrums that prey on the lives and financial resources of credulous millions," K. E. Miller, M.D., Washington, D.C., director of the Medical Advisory Division of the Federal Trade Commission, declares in an article in *The Journal of the American Medical Association* for June 1, wherein he discusses the community of interest between the Commission and the medical profession.

"A splendid contribution has thus been made," he continues, "but the full fruition of these efforts rests with regulatory measures whereby compliance with certain standards can be enforced."

Dr. Miller points out that it may not be so generally known that the Federal Trade Commission is charged with the duty of confining advertisers of foods, drugs, cosmetics and health devices to fair and truthful representations.

He says that although it is concerned with the claims made by manufacturers and distributors of drugs to the profession, the great bulk of the Commission's problems with respect to drugs has to do with preparations sold to the lay public for self treatment.

Discussing ways in which the profession can aid the Commission in safeguarding the public, as far as possible, against physical disasters born of false and misleading claims, Dr. Miller says:

"The parallel activities of the medical profession and the FTC, therefore, may be properly regarded in the light of mutual assistance. Medical testimony, either actual or potential, is the very backbone of every single case in this category. When falsehood and inuendo in this class of advertising becomes too distasteful to the physician he may take consolation in the thought that there is a way out of this wilderness, but he must at the same time realize that he or his kind will not only have to assist in blazing the trail but also lend a hand to the spade work."

BLOOD PRESSURE? PRESTO!

You are always asking, "What's new?" The Taylor Instrument Co. answer with their introduction of a manometer cuff based on an entirely new time saving principle. Fits instantly all sizes of arms without twisting or slipping. For sale by The Professional Equipment Company. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

The Periodic Health Examination

MATTHEW H. GRISWOLD, M.D., DR. P.H.,
Hartford, Conn.

In an average year among the average million persons in the United States, there will probably occur between 800,000 and 900,000 cases of illness. Of this group it is probable that 470,000 will not be ill at all but 460,000 will be sick once or twice and 70,000 will suffer three or more illnesses. One-fourth of those who become ill will be disabled for periods varying from a week to the entire year. The annual money lost in wages in families with small and modest incomes in the United States is estimated to be not less than $900,000,000 and the still larger expenses of medical care are probably not less than $1,500,000,000. The periodical health examination provides the medical profession and public health workers with a two-edged weapon against this enormous loss to the community.

Over thirty-five years ago, Gould in one of the first papers given on this continent advocating the periodical examination stated: "All good medicine inevitably tends to become preventive medicine, all good physicians labor to stop disease before it arises. The whole ingenuity of the trained diagnostician is expended on the problem of the earlier symptom. He is the greatest discover who finds the pre-symptom or the symptom of a symptom. The greatest therapist is he who cures before the disease exists, he who starves the bacillus to death, he who stops the evil habit, thus preventing the malfunction which becomes organic disease. . ."

During the past twenty-five years, phenomenal progress has been made in the conservation of health through the efforts of physicians and public health departments. Mass diseases have become almost unknown and it may be honestly said that knowledge which is now available could eliminate them almost entirely, political and financial reasons sometimes standing in the way. Today more and more thought is being given as to the best and most effective means of applying our medical knowlege to the prevention of sickness than at any period in the history of the world. Certain phases of preventive medicine heretofore considered as coming within the jurisdiction of the public health worker, however, rightfully belong to the practicing physician, the family doctor. Among these the periodical health examination is unquestionably of the utmost importance.

The periodical health examination has received the endorsement of the house of delegates of the American Medical Association and of many county and state societies, but these great national and local bodies seem to have failed to provide the people with examinations. So far, they have been unable or have not attempted to bring to the realization of the family physician that he is the man who should be making these periodical examinations and getting paid for them. Hugh Wolfenden remarks in the Canadian Public Health Journal, "It seems remarkable that we contemplate so seriously the alleviation of illness while we neglect such fundamental and elementary measures as periodical health examinations . . ."

The periodical health examination belongs to the family physician and offers him an opportunity for interesting study and an increased income. It is realized that to mention the fact that the physician should be paid for his services with something more tangible than the ephemeral praise so infrequently bestowed is still considered by many to be somewhat gauche. The fact remains, however, that doctors are just as mortal as other men and as frequently require sustenance. Any physician is justified in charging an adequate fee for adequate services, and should collect it if he can. That he should be glad to work for less than nothing if need be is a foregone conclusion already long accepted by the profession.

From the standpoint of the promotion of health, the local physician holds tremendous potentialities. He does not seem to realize this fact, that he can be an individual health unit. He should, however, be as much responsible for the health of his clients as for their care and cure during illness, and the day will doubtless come when a physician will consider it a blot upon his professional escutcheon if one of his clients becomes ill except through accident or as a result of his own misconduct.

It might be much easier to place departmental officials in charge of this branch of preventive medicine but all are agreed that the physician who is going to administer the treatment is the one who should do the periodical health examination. In other words, the family doctor. He should be educated to realize that he is responsible for the health of his clients as well as for their care during illness. In the past, public health endeavor has come in for a certain amount of criticism because it has been felt that work was being taken away from the family physician which should rightly be his. On the other hand, it can truthfully be stated that departments of health have not carried on any work for individual patients which the family doctor did not first have an opportunity to do. The public health physician, on the other hand, has undoubtedly many times lost patience with the general practitioner, feeling that he did not get the cooperation which he should have had. The general practitioner has been trained primarily in the treatment of disease and secondarily in its prevention. He has spent much money and many weary hours of hard mental effort in acquiring the knowledge which he possesses and he can't change his point of view over night. It is well that this is so and that the doctor is prone to be cautious about adopting new ideas until they have been proved. But the value of preventive medicine has been so conclusively demonstrated over so many years, that the physician can no longer refrain from practicing it because it is new and untried. It should be pointed out to the general practitioner that it is to the advantage of his clientele to practice personal preventive medicine and that it is a more remunerative branch of the art than the curative.

The highly confidential relations between physician and patient, resulting from the discussion of physical and mental states, personal and social relations and domestic stresses, must of course be maintained. Inspired by mutual trust and a common interest, these relations cannot be created by economic subsidies nor forced by legislation.

The conduct of health examinations is no more difficult than most other procedures in medicine, but it is far more inclusive. Above all things it must not be casual or colored by prejudice. The attitude of the physician undertaking a periodical examination is important as well as the technique of its performance. Painstaking thoroughness in regard to every detail of the examination is essential. If the physicians who read this article will answer to themselves the question, "Do you routinely do a rectal on all new patients and a vaginal on all female patients," they will know whether or not their examinations are adequate. Rectal bleeding apparently resulting from hemorrhoids may be due to cancer. The two may of course be coincidental. And by "vaginal" is meant a thorough inspection through a speculum (or colposcope) and not the usual cursory digital prodding so often considered as adequate. Granted that a man may have "eyes in the ends of his fingers," can those eyes see in the dark? No man, however experienced, can "see" a very early cancer of the cervix with his fingers, nor can he see precancerous lesions in this manner.

The patient of today is learning to expect when he demands a periodical health examination that the physician will first take a careful and complete family and personal history and moreover he expects to see that history recorded in such a way that it can be filed for future reference. As to the actual examination itself, he looks forward, perhaps not with a great deal of pleasure to a careful, painstaking inspection of all of his body that can be seen, felt or listened to without resorting to major surgery. He also expects that adequate laboratory tests such as urinalysis, blood count and proper blood test for syphilis will be made and any other further procedures such as x-rays, basal metabolism test, blood chemistry and so forth will be done if indicated. In other words, the patient of today expects when he asks for a periodical health examination to get one that is thorough in the true sense of the word.

These patients are also being educated to expect that an adequate charge will be made for examinations of this kind. They realize that the physician is justified in charging for the extra time involved and the various laboratory procedures necessary as well as for x-ray and other diagnostic methods which may be required. This factor of cost is at present one of the greatest stumbling blocks in the way of the periodical health examination for it is unquestionable that a large percentage of the population of this or any other country are not at the present time and perhaps never will be in a position of sufficient financial independence to make it possible for them to pay a physician an adequate fee for such an examination. Neither is it probable that the physician will be able to greatly reduce his charges for these examinations if he is to continue to make them as they should be made. There is, however, a considerable number of the population who can afford the annual physical examination and it is toward these at the present time at least that our attention should be directed.

The first thing the physician must learn to be interested in if he is to adequately perform periodical health examinations is the presymptom rather than the symptom since it is out of the former that the latter arises. Frequent colds, indefinite digestive disturbances, nervousness, fatigue, worry, slight indefinite pain: — all these things are considered by many as unimportant negligible symptoms which do not point to any particular pathological state. These things are, however, the presymptoms which in many cases do point the way to distinct pathological conditions.

Illustrative of the value of the periodical health examination as a method of disease prevention particularly among adults are the figures compiled by numerous students of the problem.

Experience in a large financial organization shows that among 298 employees accepting the offer of a periodic examination, 769 impairments were found, or 2.57 for each employee examined. Forty-one or 13.7 per cent were referred to the family physician for treatment. At the end of four years 440, or 57.2 per cent of the 769 defects had been remedied.

From this small group two facts seem to stand out:

1. Of supposedly healthy young people 13.7 per cent had impairments needing actual medical treatment.

2. The advice of the examining physician was acted upon with the result that 57.2 per cent of these defects were corrected.

In 1925 a railroad company in the eastern United States examined 5,393 employees and found 2,751 or 51 per cent with impairments which would definitely shorten life unless corrected. In the course of three years it was found that 2,434 or 89 per cent of this group, had had their impairments corrected. In 1925, 51 per cent of the group of 5,393 railroad employees required medical care, in 1929, 9.38 per cent.

A group of actively employed post office workers showed the following classifications:

Class 1. Moderate defects requiring medical supervision as well as hygienic correction: 26 per cent.

Class 2. Advanced physical impairment requiring systematic medical or surgical attention: 30 per cent.

Class 3. Serious physical defects requiring immediate surgical or medical attention: 39 per cent.

Examination of 1,020 men applying for health diagnosis service showed 120 to have hypertension. Of these 100, or 84 per cent, made an average of 16 return visits. The average age was 47 years (range from 21 to 78). 90 per cent considered their health above average, 58 per cent considered it optimum, 3 per cent considered it below normal, none that it was poor. An average of one physical defect and four faulty health habits was found.

Results were as follows: 78 men returned regularly and reduced their blood pressure an average of 18 mm. Hg. This level was found at final readings taken from two months to five years after the initial readings. Twenty-two men did not lower their blood pressure because of organic disease or failure to correct their faulty health habits.

Overweight was a cause of hypertension in 40 cases, but the by-products of incomplete metabolism caused by habitual over-eating were apparently more potent causes of hypertension than weight itself.

No case was found of "essential" hypertension. It is believed that this term is a misnomer applied in cases in which no accurate diagnosis is made. Only one man with possible "hereditary" hypertension was found. Experience indicates that hypertension is a symptom and is not a disease; that this symptom is caused more often by faulty health habits than by physical defects; that patients with hypertension are interested in correcting both physical defects and faulty health habits and in rearranging their daily program of living when definite directions are given them; that health diagnosis is an essential part of adequate medical diagnosis, and is not sufficiently stressed in modern medical practice.

That early curable cancer can be and is detected at health examinations is an accepted fact. To be sure early cancer in some sites can be diagnosed with difficulty and perhaps few early cancers of the stomach, for instance, will be found. But enough beginning malignant lesions of the skin, breast, cervix, mouth and other accessible sites should be found and corrected to make the effort well worth while.

In the past, physicians have approached the problem of periodic examinations without enthusiasm, perhaps largely because they have associated applicants for annual examinations with introspective, neurotic individuals.

Because of educational work, especially in cancer, physicians may expect to encounter more and more demand for the health examination. Such patients as wish this service will seek and ultimately find physicians who are willing to give the deliberate and painstaking examination the public is being educated to expect.

BIBLIOGRAPHY

Brandabur, J.J., "Importance of Periodical Physical Examinations," *West Virginia Medical Journal*, 33: 125-129, March 1937; *Abstract Ohio State Medical Journal*, 33: 651-652, June 1937.

Emerson, W.R.P., & Irving, J.G., "Hypertension and Health Diagnosis; Study of 100 Cases," *Journal of the American Medical Association*, 111: 1174-1178, September 24, 1938.

Goodrich, C.H., "By-Products of the Periodic Health Examinations," *New York State Journal of Medicine*, 38: 127-130, January 15, 1938.

Harrison, H.M., "The Periodic Health Examination From Various Viewpoints," *Canadian Public Health Journal*, 27: 61-66, February 1936.

Ministry of Public Health, Province of Quebec, "The Periodical Health Examination." *Bulletin Sanitaire*, November, December 1938.

Ottenheimer, E.J., "The Annual Physical Examination," *Cancer, a Handbook for Physicians*, Connecticut State Department of Health, 1939.

Perkins, W.H., "Present Status of the Health Examination," *New Orleans Medical and Surgical Journal*, 90: 387-392, January 1938.

Rentschler, E.B., "Importance of Examinations Relative to Heart Disease," *Pennsylvania Medical Journal*, 42: 139-141, November 1938.

Sensenich, R.L., "Quantity and Quality of Life." *Journal of the Indiana Medical Association*, 31: 437-439, September 1938.

Shelby, E.P., "Balancing the Physical Budget," *Hygeia*, 14;819-820, September 1936.

Shurly, B.R., "The Family Doctor," *Journal of the American Medical Association* (Organization Section), 108: 169B-172B, May 22, 1937.

Sydenstricker, Edgar, "The Changing Concepts of Public Health," *The Milbank Memorial Quarterly*, Vol. 13, No. 4, 1935.

☆☆

SELF-EDUCATION vs. INSTRUCTION

Furthermore, it is most important that the specifications of training shall not become too rigid. There is gentle irony in the fact that men who to a large extent were self-taught believe that their successors cannot achieve an education in the same manner. Instruction is a short cut to knowledge; properly imparted and assimilated it will greatly accelerate the acquisition of knowledge and will prevent many a needless mistake, but all the instruction in the world will never eliminate the need for self-education. It is fair enough to demand proof of qualification, but the gateway must never be closed to the man who chooses the unconventional and original approach. By present standards Harvey Cushing's training in brain surgery was shockingly inadequate!

Edit., N.E. Jour. Med., June 27, 1940

The Connecticut State Medical Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief*, Hartford
Sidney G. Davidson, New Haven
Frank Stafford Jones, Hartford
Charles Mirabile, Hartford
Oliver L. Stringfield, Stamford
Herbert Thoms, New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — Harold E. Speight, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

A PLEA FOR CONSERVATISM

The electrocardiograph has been available for more than twenty-five years, yet the question is now being seriously asked in many quarters whether its use should not be greatly restricted instead of enormously extended. The reason for the question is obvious. With the advent of portable and relatively inexpensive machines in recent years, and the high-pressure salesmanship that strives to place one in every office in the land, it has become almost the rule for physicians beginning practice to secure an instrument as part of the standard office equipment, together with a stethoscope and a sphygmomanometer. Needless to say, it has become an essential and inevitable part of the equipment of every practitioner who becomes a "heart specialist" after a course of study lasting from two to six weeks.

Unfortunately, while the technique of recording electrocardiograms can be learned in a few minutes, the proper interpretation of the more difficult records often requires months or years of study, checked and controlled by clinical experience and postmortem examination. The ability to recognize the common disturbances of rhythm, such as premature beats, heart block, and auricular fibrillation or flutter, is easily acquired, but in most of the common arrhythmias the electrocardiogram serves merely as confirmation of a clinical diagnosis that has already been made with confidence; comparable in some respects to the x-ray film of a bone that is known to be fractured. In the great majority of cases of coronary thrombosis the electrocardiogram yields valuable and even pathognomonic diagnostic information, and in many instances of acute pericarditis and pulmonary infarction the records are of great significance. But often the recognition of these specific meanings requires considerable experience and the recording of three or more curves at short intervals.

It is a matter of common knowledge that there are now hundreds — perhaps thousands— of electrocardiographs in use by physicians who have had little or no training in the interpretation of records and who are wholly lacking in the experience and judgment essential for their proper clinical application. The clinical diagnoses made by such men, on the basis of electrocardiograms alone, would be merely ridiculous if they did not so often affect the lives of their patients seriously and even tragically. Their important mistakes seldom consist of overlooking serious abnormalties, but rather in reading into the electrocardiogram a significance that it does not possess. Diagnoses of serious heart disease are made on the basis of the curves alone when this is entirely unjustified. Competent specialists in the cardiovascular field have the frequent experience of encountering patients who have been condemned to inactivity or invalidism, or who suffer from a profound cardiac neurosis, because of a diagnosis of "coronary diesase," or "myocarditis," or "myocardial damage," based entirely on minor changes in the electrocardiogram that have no specific meaning. There is complete agreement among authorities that such diagnoses should never be made on the electrocardiogram alone; one of the foremost among them has said this:

"In general it is most unwise to base any diagnosis which involves a commitment as to the presence of coronary abnormality of any kind upon the electrocardiogram alone. To make a diagnosis of coronary sclerosis or of angina pectoris from the electrocardiogram alone is impossible. The electrocardiographic tracings should be interpreted with a full knowledge of the clinical findings; and the electrocardiogram should be given no more and no less weight in reaching a final conclusion than other clinical or laboratory data."*

The inexperienced physician who makes unwarranted diagnoses without hesitation is chiefly, but not wholly, to blame for the present deplorable situation. The physician who refers patients for electrocardiograms and then unquestioningly accepts such diagnoses must share the responsibility. It is astonishing that a man who would scorn to accept a slight increase in the leukocyte count alone as clear proof of appendicitis or pneumonia readily accepts a slight and unimportant alteration in the electrocardiogram as proof of "coronary artery disease," and bases his prognosis and treatment upon this diagnosis.

The situation has become so grave that a number of eminent authorities have seriously proposed the establishment of a Licensing Board for the sole purpose of certifying the laboratories or individuals who are qualified to interpret electrocardiograms. It seems unlikely that so radical a step must be taken immediately, but if the widespread abuse of an important diagnostic instrument continues, the medical profession will almost certainly impose some form of restriction in the near future.

The proper solution of the problem is to be found in further training and experience for those who are charged with the intrepretation of electrocardiograms that have a serious connotation. If this cannot be secured readily or without great sacrifice, inexperienced physicians should recognize their limitations and should submit their curves to recognized authorities for interpretation. There must be few regions indeed where such expert help is not available by mail within a few hours, and without cost.

The time has come to end permanently a practise that is causing untold physical and emotional suffering and is bringing the electrocardiogram into widespread disrepute. Every physician in Connecticut can and should play an active part. Let us recognize that the electrocardiogram is merely a laboratory procedure, with inherent and wide limitations, which seldom gives specific information as to the function and structure of the heart. Let us acknowledge that a diagnosis of coronary artery disease based on a minor alteration in such records is precisely analogous to a diagnosis of carcinoma based on a slight increase in the sedimentation rate of the red corpuscles. Let us refuse, now and henceforth, to accept such diagnoses as "coronary disease" and "myocardial damage" on the basis of electrocardiograms unless these curves are amply confirmed by clinical findings or the diagnosis is made by a recognized authority.

H. M. M.

---

*Wilson, Frank N., The Electrocardiogram in Disease of the Coronary Arteries. Chapter XII in "Diseases of the Coronary Arteries and Cardiac Pain," edited by R. L. Levy, New York, 1936, Macmillan, page 326.

CONNECTICUT AND THE NATION'S DEFENSE

The people of this nation, physicians and laymen alike, are today concerned with what each of us can do to contribute to the safety of our country. We look forward to the time that lies just ahead without hysteria or motives of aggression, and as time goes on our course to total defense measures will become clearer and medicine will have no inconsiderable part.

The Connecticut State Medical Society numbers in its membership nearly 1800 physicians or about 80% of the total medical personnel in the State. As the program of mobilization for defense progresses and in the unlooked for event of hostilities our services will be required. Recollections of 1917 bring to mind that medicine was mobilized rather hastily and without a well defined program. In times of stress the health problems of the military and civilian population are inseparable and it is hoped that now there will be a closer application of the medical and public health sciences to the physical problems of a nation at arms.

Whatever the national program for medical preparedness for war may be, each state will have local conditions that are to be met. These problems will vary with geographical location, density of population, industrial character and transportation resources.

Connecticut is an industrial State that has been called "the arsenal of America," and its location on the Atlantic seaboard exposes it to many peculiar dangers. Industries are certain to expand rapidly in the preparedness program. This expansion after the long period of comparative inactivity will bring in inexperienced labor, and new manufacturing processes will present health hazards which will require constant medical interest if the highest worker efficiency is to be maintained. The nation is interested in production and more production and it cannot be retarded by the loss of time and disability of its workers.

Connecticut will feel the impact of the preparedness effort in her industries first and it is there that our physicians can make a great contribution. They will be called upon to help devise new methods to prevent and treat accidents; they will be confronted with the necessity to gain new knowledge of the effects of chemical hazards and dusts; they must have a sympathetic and wise understanding of the emotional reactions of industrial speed-up.

There are already in this State many physicians well trained by fine experience in these fields but additional personnel will be required and it may be that here can be developed a valuable training area for physicians and nurses and technicians so that men may be safeguarded and kept at work. The present challenge to Connecticut medicine is to make and keep its men as good as it machines.

C. B.

* * * *

THE GRADUATE MEDICAL STUDENT'S PROBLEM

During a recent ten day period in June reports of graduate training facilities for interns and residents have come to the Editor's desk from three different sources. This is a significant fact, one which emphasizes the importance of the problem facing the student as he graduates from medical school today. He must decide whether to pursue a specialty or become the epitome of all specialties, the embodiment of all that the practice of medicine formerly stood for in its relationships between physician and patient, — the general practitioner. Much has been said or written of the need for more training in the care of the patient, better preparation in the specialties, and a broader foundation in the basic sciences. There has been advocated in some quarters a college course of four years, devoted almost entirely to the classics and to the humanities. This would provide sources of potential personal resourcefulness and a broader viewpoint, a widening of the horizon beyond that which is solely medical. Then would follow four years of medical school, two years of internship, one to three more years of residency. The vulnerable point in this program is that the doctors are no longer young when at last they are ready to practice, and, therefore, some part of the graduate medical educational program should be simplified or eliminated.

Since 1930 there has been an excess of internships in relation to the annual output of the American medical colleges, present figures showing that the demand for interns does not greatly exceed the supply of available candidates. The Commission on Graduate Medical Education now suggests that the internship should be considered as a basic preparation for the practice of medicine, rounding out and putting into practical use the knowledge acquired in medical school. It further states that the internship should prepare for general practice and at the same time lead to further study in preparation for practice in a specialty. Internal medicine, pediatrics, obstetrics and gynecology, surgical diagnosis, minor surgery and treatment of emergencies are all considered within the scope of the intern's training. Particularly emphasized are preventive medicine, the care of chronic diseases, conditions of the aged, and functional disturbances. All this to be included in a two year program!

The graduate medical student may wish to enter upon the practice of some particular specialty. To do so he must acquire a residency in an hospital approved for such training by the Council on Medical Education and Hospitals of the American Medical Association and by the specialty boards. Within the last two years the Council and the specialty boards have entered into cooperation for the joint study and appraisal of fellowships and residencies in the respective specialties. There is now a uniform method of hospital investigation, making possible the publication of a list of approved residencies and fellowships equally acceptable to the Council and to the certifying boards. Certain essential qualifications are stressed for hospitals offering residencies, in particular, adequate training in the basic sciences as they relate to the various specialties. There is a danger that too many residencies with inferior teaching facilities may become available to the young graduate student.

The American College of Surgeons has just published a Manual of Graduate Training in Surgery. This sets forth in detail the requirements for proper training in this field, and emphasizes the correlation of the basic sciences with supervised clinical experience. The College recognizes the opportunities for graduate training in universities, teaching hospitals and in recognized clinics, but it challenges a large group of hospitals not directly affiliated with institutions, but actively engaged in teaching, to develop programs for graduate training in general surgery and in few of its specialties.

To assist the young graduate student in his choice of an internship and a residency the Council on Medical Education and Hospitals has made available a list of hospitals approved for intern training. This list now includes figures showing the percentage of patients available for intern training, the number of dental internships provided and the number of internships available for women. It has also made available a list of approved residencies, now covering thirty specialties and including 4,233 approved residencies and 649 approved fellowships.

The problem of graduate medical education belongs not alone to the student. For him standards have mounted and requirements multiplied, but at the same time the implications for the profession at large have increased. As practitioners of medicine our relationship to the graduate medical student is more than that of one fellow member of society to another. As members of hospital staffs we must make every effort to enable our institutions to meet the standards set by the American Medical Association, the American College of Surgeons, the American College of Physicians, and the certifying boards, in order that in so far as possible we may participate in the program of improved medical training. This is but one phase in the evolution of medicine to assure a higher quality of medical care to a greater number of citizens in the entire United States.

* * * *

OUR GREETINGS TO TWO NEW JOURNALS

Two new Journals have come to our desk during the past month, Anesthesiology, the Journal of the American Society of Anesthetists, Inc., and the Quarterly Journal of Studies on Alcohol. The first of these two, appearing with its initial number in July, presents a very simple and attractive appearance with its cover containing the seal of the Society. The format will appeal to one who enjoys a neat, well printed and readable journal and the contents of this first issue covers much of interest to all who practice medicine. The

Editor is Doctor Henry S. Ruth, well known in anesthesia circles, and one of the two Associate Editors is Doctor Ralph M. Tovell, chief of the department of anesthesia of the Hartford Hospital. We feel certain that much of the credit for this journal belongs to Doctor Tovell. Our sincere best wishes for a bon voyage.

By a strange coincidence the second journal referred to above comes to us accompanied by a letter from one of the Editorial Board, Doctor Howard W. Haggard of Yale University, who is also the contributor of the first article in Anesthesiology on "The Place of the Anesthetist in American Medicine." Doctor Haggard writes, "With the discontinuance of the British Journal of Inebriety this is now the only scientific periodical in the English language devoted solely to the problems of alcohol." This Journal is the official organ of the recently formed Research Council on Problems of Alcohol and should be of particular interest to numerous groups in medicine and out. The first issue under date of June, 1940, contains several excellent articles on different phases of alcohol as it affects the individual as well as society, and in addition several pages of medicolegal reviews and abstracts of current literature. To the editors of this new publication we also extend our cordial greetings and good wishes.

* * * *

TESTIMONIAL DINNER FOR DOCTOR GEORGE BLUMER

About 300 persons attended a testimonial dinner at the Hotel Taft, New Haven, June 17, 1940, given in honor of Doctor George Blumer on the occasion of his retirement from active service in the School of Medicine, Yale University.

Former students, his associates and colleagues gathered to show their respect and affection for George Blumer, who for 34 years has faithfully served the University, the community and the state.

In the University he was successively Professor of Theory and Practice of Medicine, John Slade Ely Professor of Theory and Practice of Medicine, David P. Smith Clinical Professor of Medicine, and from 1910-1920 Dean of the School.

Doctor Blumer was President of the Connecticut State Medical Society for the year 1920-1921 and since 1932 has been a delegate to the American Medical Association.

Doctor Francis G. Blake was toastmaster on this occasion. Talks extolling Doctor Blumer's capabilities and telling of his pleasant shortcomings were given by Dean Stanhope Bayne-Jones, president-emeritus of the University, Doctor James R. Angell, Doctor Milton C. Winternitz, Doctor William F. Verdi, and Doctor Fu-chun Yen, a graduate of the School, a former student of Doctor Blumer's, and Minister of Health of the Republic of China.

Doctor S. J. Goldberg, on behalf of friends, presented Doctor Blumer with a suitable gift. Doctor Blumer responded in his usual interesting manner and expressed his deep gratitude for the testimonial.

—☆☆—

INDUSTRIAL HEALTH

Thirty-four state medical societies have created committees on Industrial Health rather recently, and it will be through their activities undoubtedly that the whole subject will be placed on a proper plane and such deficiencies as exist will be eliminated.

In twenty-nine states, the health department has assumed the responsibility of industrial health through industrial hygiene bureaus utilizing some thirty-three physicians. The oldest of these, Ohio, dates to 1913; New York in 1913; the next is Connecticut in 1928; then Mississippi in 1929 and the rest after 1934. The personnel of these combined departments comprises 51 engineers, 36 technical aids and 39 clerical assistants in addition to the medical staff already noted. Considering the area covered and the great number of industries within this scope the force is obviously inadequate.

Any improvement must be developed through the creation of public sentiment favoring a greater consideration of this whole field. It is gratifying to note the doctor's interest and those of us either directly or indirectly concerned should cooperate with these new committees to the fullest extent of our capacity since it is in this field that preventive medicine of the future is to find its greatest usefulness and the doctors their most profitable occupation.

Weekly Roster, Mar. 30, 1940

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

DUES REMINDER

As the middle of the year passes, County Secretaries will welcome the payment of dues from those who have neglected it up to now. In spite of the necessary increase in the annual assessment, payment has been prompt from well over half of the members of the Society. At the time of the last accounting by the County Secretaries on June 1, the records stood:

County	*Members Paid*	*Total Membership*
Fairfield	223	368
Hartford	334	432
Litchfield	57	75
Middlesex	31	65
New Haven	295	510
New London	59	116
Tolland	10	17
Windham	27	40
	1036	1722

* * * *

STATE CHAIRMAN ON MEDICAL PREPAREDNESS

The National Committee on Medical Preparedness has requested that a chairman on medical preparedness be appointed in each State and in accordance with the suggestion offered by the National Committee, the President, Chairman of the Council and Secretary of this Society have given the subject thorough consideration and named George M. Smith of Pine Orchard to that important position. Doctor Smith will direct the Secretary's office in the coordination of Connecticut's part in the national medical preparedness program.

* * * *

COMMITTEE ON PREPAID MEDICAL SERVICE

The Committee on Prepaid Medical Service under the Chairmanship of Samuel C. Harvey met in conference with physicians from all over the State on June 19. The purpose of this conference was to learn the opinions as to the need of a plan for prepaid medical service here. The representatives in the conference were chosen by the Presidents of the County Associations and were:

James P. McManus, Bridgeport; Samuel F. Mullins, Danbury; Ralph W. Crane, Stamford; Berkley M. Parmelee, Bridgeport.

John E. Darrow, New Britain; William T. Morrissey, New Britain; Maurice T. Root, West Hartford.

Brae F. Rafferty, Willimantic; Karl T. Phillips, Putnam; Morton Arnold, Willimantic.

Joseph I. Linde, New Haven; Frederick N. Sperry, New Haven; Cole B. Gibson, Meriden; Albert E. Herrmann, New Haven.

Charles Russman, Middletown; Carl C. Harvey, Middletown; Hazen A. Calhoun, Middletown.

Clarence G. Thompson, Norwich; Joseph J. Mahoney, Norwich; William Schneider, Rockville.

From the Committee: Samuel C. Harvey, Chairman; Thomas P. Murdock, Daniel P. Griffin, Oliver L. Stringfield and Arthur B. Landry, President, Creighton Barker, Secretary.

* * * *

THE TUMOR COMMITTEE AND THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER

Acting under approval granted by the Council the Tumor Committee of the Society has proceeded with the details of the agreement between the Committee and the American Society for the Control of Cancer. The articles of organization and the form of the agreement were developed at a meeting of the Committee in Waterbury on July 1. Present were:

Charles L. Larkin, Chairman; Philip G. McLellan, Edward J. Ottenheimer, Louis P. Hastings, Charles J. Bartlett, Maurice R. Moore, Francis A. Sutherland, Edward W. Foster, Stanhope Bayne-Jones, Ashley W. Oughterson, Stanley H. Osborn, Creighton Barker.

CONNECTICUT AT THE AMERICAN MEDICAL ASSOCIATION

Four hundred and twenty-seven members of The Connecticut State Medical Society registered at the convention of the American Medical Association in New York in June. Under the reapportionment of delegates Connecticut continues to have two delegates.

To the Editor:

Letters to the Editor

The American Neurological Association, in its Executive Session at the Westchester Country Club, Rye, New York, on June 7, 1940, unanimously passed the following resolution and directed its Secretary to send copies of this resolution to the Secretary of each State Board of Medical Examiners and to the editors of the Journal of the A.M.A. and of each State Medical Journal:

Whereas official statistics indicate that the immigration of refugee physicians is numerically small, representing in its totality less than 6% of the practising physicians of this country;

And Whereas such an influx of physicians from abroad cannot adversely affect the economic welfare of American physicians if the emigres are distributed widely to those sections of the land in which they are needed;

And Whereas information gathered from governmental and private investigations indicates that there are at least 2,000 communities in this land in need of immediate medical staffing which in large part cannot be supplied by the graduates of our own medical schools;

And Whereas many of the demands for physicians come from states in which it has become impossible, either by reason of legal enactments or because of regulations of the State Boards, for the refugee physician to take his medical license examinations;

And Whereas there now exists in New York a competent agency for diverting the unfit among the refugee physicians into non-medical fields thus making it possible only for those who are fit in training and in personality to be considered for examinations;

Now Therefore be it Resolved that the State Boards of Medical Examiners in the United States shall create a uniform policy with regard to refugee physicians so as to make possible the wide distribution of these physicians to those places where they are needed throughout the land;

And Further that these uniform changes in the regulations of our State Boards shall be in the direction of the recommendations made by Dr. David L. Edsall in his article on "The Emigre Physician in American Medicine" (Journal of the A.M.A., March 23, 1940, Volume 114, pages 1068-1073);

And Finally that the Committee for Resettlement of Foreign Physicians of the National Refugee Service, Inc., 165 West 46th Street, New York City, shall be utilized as a clearing house for information in regard to available emigre physicians for specific placements.

Very truly yours,
Henry Alsop Riley, M.D.
Secretary
American Neurological Association

The Committee on Medical Preparedness of the A. M. A. asked you for data. Did you furnish it?

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Paevex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

Connecticut Hospital Association

MEDICAL RECORDS

Enna Black, Vice President
Connecticut Association

The Connecticut Association of Medical Record Librarians met in conjunction with The Connecticut State Medical Society on May 22, 1940, at the Bond Hotel in Hartford. An interesting and instructive program was presented.

The beginning of the hospital standardization program was started in 1918 by the American College of Surgeons who, supported by other allied organizations, has been greatly responsible for the progress in medical records since that time.

The Record Librarians of Connecticut organized their Association in May, 1928, and the American Association was organized in October of the same year. These organizations were formed with the following "Objects" in mind: To elevate the standard of clinical records in hospitals and dispensaries; to serve as a means of intercommunication among record librarians; and to encourage the training of record librarians to the end that they may render intelligent service in that capacity. Ten training schools have been established in the United States and standards are being raised each year.

All Chief Record Librarians must be registered and are required to pass a rigid examination. The Record Librarian of Grace Hospital is Chairman of the National Board of Registration.

Complete records are most important to the patient. The medico-legal aspects arising out of many accident and injury cases require that the medical records of the hospital be available to supply the necessary facts and clinical data necessary to assure the patient adequate protection of his rights. No information is given from the record without the written consent of the patient and records are not removed from the hospital except by an order from the Court. When a patient comes under the care of a physician unfamiliar with his past record of hospital admissions, the hospital medical record is frequently consulted to give a detailed clinical resume of previous illnesses and their possible bearing upon the illness at hand.

Medical records, used as impersonal documents, are very valuable in research work. Only because there were people with the ideals of the modern record librarians in those days, do we know that about 6000 years ago in some torch-lighted, smoke-filled temple in ancient Egypt, men, women and children gathered for treatment. Here under the flickering torches the priests, who were the physicians of those days, administered treatment to the afflicted. That such gatherings were common and that the temples corresponded to the hospitals of today we know, because there were the professional ancestors of record librarians at work who described the disease and the treatment and recorded the end results. These beginnings of patients' records were written on stone and clay and parchment, and entirely to them do we owe the knowledge of the medical practices of that ancient time.

* * * *

MEDICAL RECORDS AT BRISTOL HOSPITAL

The administrator's task in securing complete medical records is a difficult one. No matter how efficient a Record Librarian or her assistants may be, and in spite of well-meaning and cooperative Staff members it seems to be almost impossible to have the history and physical examination, progress and operative notes completed in a given length of time. Thanks to very fine cooperation on the part of our Executive Committee and our efficient Librarian, a plan was worked out which has proven very efficacious in our hospital. As we employ only Residents, our doctors are held responsible for writing records on their private cases. Two weeks leeway is allowed a doctor in completing a record. Five days before a given time expires a letter is sent by our Record Librarian calling the doctor's attention to the fact that the two weeks period will expire shortly. This is a form letter and is as follows:

Dear Dr.

As you know, the Bristol Hospital is exceedingly anxious to assist the members of the staff in every possible way to keep histories up date. As you are also aware, the unsatisfactory condition of our histories during recent years has forced upon the Executive Committee the necessity of adopting a rule that members of the Staff failing to complete histories within two weeks after a patient has left the hospital will be deprived of the privilege of admitting further patients until the histories in arrears are completed.

Naturally exceptions to this rule can be made only because of some unusual extenuating circumstance, and realizing how embarrassing it can be to a member of the Staff to be temporarily deprived of the use of the hospital, I am taking the liberty of calling your attention to the fact that you have not yet completed the histories enumerated below, which will shortly run over the two weeks period.

I hope very much that you will realize the co-operative spirit in which this letter is written and will take advantage of the information to bring your histories up to date.

Cordially yours,
Record Librarian

If at the end of the two weeks, the records are not complete a second and final letter is sent:

Dear Dr.

The records of the History Department of the Bristol Hospital show that you have the following incompleted histories covering patients who left the Hospital over two weeks ago:

Name	Date of Discharge.

As you have been advised, the Executive Committee on April 17, 1939, voted unanimously that histories must be completed within a period of two weeks after a patient leaves the hospital, and that any doctor failing to comply with this provision would be deprived of the privilege of admitting further patients until histories in arrears were completed. This action was taken after long deliberations and in the feeling that such a course was imperative if we were to maintain our Grade A rating — a standing important to the doctors and community alike.

In accordance with the above, we are compelled to advise that we cannot allow you to bring further patients to the hospital until your histories in arrears are completed.

May we express the hope that we may have your wholehearted co-operation in maintaining a good History Department.

Very truly yours,
Secretary, Executive Committee

Strange as it may seem our doctors have cooperated very nicely with the Executive Committe on the new rule, and with few exceptions have appreciated our difficulties and have been willing to give us their help. A few doctors have been dropped from the staff for a period varying from a few hours to a few days, but in every instance the records have been completed before the doctors hospital privileges have been restored.

We are extremely fortunate in having a very active and interested Executive Board to work with us, and whose word is final.

* * * *

COST ACCOUNTING AT GRACE HOSPITAL, NEW HAVEN

For a number of years this Hospital followed the general outline of accounting approved by the American Hospital Association. However the change in economic conditions has so drastically curtailed contributions that it has become necessary to secure adequate compensation for services rendered, especially for services rendered where the various divisions of governemnt — towns, counties, cities, and states — are responsible for the payment of the Hospital bills. This must also hold true with insurance companies and other organizations.

While sound business administration would seem to have demanded that we know our exact costs many years ago, it is imperative that we know them now, when we must discuss increased rates with these organizations.

With this thought in mind, the Hospital auditors were called into consultation early in 1938 and it was agreed that a complete cost system should be developed. Early in July of that year, an accountant was assigned by the auditing firm to this work. He began by making a careful analysis of the distribution of such items as heat, light, power, water, etc., to all of the various Hospital departments. In like manner of analysis, he distributed all other overhead costs until every department was allocated its proper share of operating expense. Following that, the expense of all non-earning departments were allocated to the earning departments in their proper proportions. For instance, the Operating Room as an earning department, bears its proportionate share of the costs of general administration, housekeeping, light, heat, power, laundry, nursing, and so forth. Incidentally, the cost of nursing includes housing, feeding, laundry work, maintenance of dormitories and its proper share of all the other everhead expenses.

These figures, once accurately allocated, are not changed unless some new operation is undertaken which should affect the costs.

With the cost of each service and the number of services rendered by each department accurately determined, we obtain the average cost of each service rendered by each department, and from this figure, we are able to determine the cost of the care of various types of patients, ward, private, etc. For example, in arriving at the cost of caring for ward patients, we take the cost of all services rendered—room, board, nursing care, Operating Room service, X-ray, and so forth, and are then able to determine the exact cost of the care rendered to ward patients. The cost of care for private patients, children and new-born babies is obtained, of course, in the same manner.

This system has been laid out in supplementary ledgers and each month we have a report giving us the exact cost for various services and the exact cost for the care of various types of patients.

We now find ourselves in a position to discuss intelligently with any agency what our costs are and what the rates must be in order to maintain the Hospital adequately.

* * * *

STANDARD CHARGES

The Committee appointed by President Allen, consisting of Brough of Norwalk, Hancock of New London, and Wieler of New Haven, to secure from the member hospitals the rates and charges for various services, is busily engaged on this long, ardous and difficult task. The Committee divided the State into three sections and each member of the Committee is securing the information from the hospitals within his area. Reports are coming in slowly and the Committee urges upon the Superintendents that they furnish the required information at the earliest possible date.

A brief study of the various rates, already received, indicates the necessity of our institutions making a concerted effort to standardize rates and charges.

This need has been very definitely shown in the contact which the Committee on Compensation Rates has had with the insurance carriers. Discussions with the insurance carriers and with the Compensation Commissioners by this committee have been complicated because of the variation of per diem charges made by the various institutions.

It is evident that there is a growing tendency due to increased education of the public regarding hospital operation, for all agencies to pay the hospitals an adequate return for services rendered, such return to be based upon the cost of rendering the service.

* * * *

WINCHESTER HOSPITAL IN WEST HAVEN TO CLOSE

According to the daily press the Board of Directors of the New Haven Hospital has decided to close the William Wirt Winchester Hospital in West Haven and to transfer the tuberculosis service from there to the New Haven Hospital. The Winchester Hospital has been operated at a loss since its opening under the management of the New Haven Hospital in 1927. There appears to be little need any more for an institution of this type. Connecticut now has a ratio of approximately three sanitoria beds per annual death from tuberculosis, one of the highest ratios of any state and twice as high as that of the country as a whole.

The history of the Winchester Hospital is an interesting one. Established for the care of tuberculosis patients in 1916, through the gifts of Mrs. Sarah L. Winchester, it was leased to the Federal government in March, 1918, and established as U.S. Army Hospital No. 16 for tuberculous soldiers. After the armistice it was transferred to the Public Health Service and later to the Veteran's Bureau, finally reverting to the New Haven Hospital nine years after its completion.

* * * *

FROM CHARLOTTE HUNGERFORD HOSPITAL

Doctor Albert W. Buck was a member of a Commission which served as a Board of Examiners for 207 candidates for the position of Institutional Storekeeper under the merit system. Other members of the Commission were Colonel Raymond F. Gates of Fitch's Home for Soldiers and Mr. C. LeRoy Magnuson of the State Purchasing Department. Written examinations were given to 152 candidates and personal interviews with 68 were held on July 11 and 12.

The fiscal year of the Charlotte Hungerford Hospital closed on June 30. Some of the following statistics are illustrative of the year's activities: Number of patients admitted to Medical Service 709; Surgical service 1192; Obstetrical 574; Newborn 553; E.E.N. & T. 459; total 3,487. Patients' days care given, 35,780. Maximum census for any one month, 131. Daily average census, 97.7. These figures represent the greatest amount of service rendered by the hospital during the twenty-four years of its existence.

At the annual meeting of the Charlotte Hungerford Hospital Auxiliary the following officers were elected for the ensuing year:

Mrs. Chas. E. Bennett — President
Miss Alice Mulcunry — Vice-President
Mrs. Edward E. Mackintosh — Secretary
Mrs. John H. Thompson — Treasurer
Mrs. Wesley Roche — Auditor

* * * *

EDITOR'S NOTE

We recommend to our readers that they read the article in the July issue of HOSPITALS written by Dr. Walter Goodale of Buffalo, entitled: "Nurses Training — Streamlined." The Editor would be glad to receive comments from our readers regarding this article.

-The- General Practitioner's Forum

Study of "A Symposium on the Practical Management of Acne Vulgaris" in the April, 1940 J. of Invest. Dermat., reveals an encouraging unanimity of opinion but nothing new as to causative factors or specific therapy. In this paper, the six authors agree that vaccines, toxoids and endocrines are useless; that vitamins, tonics and other internal medications, except for specific therapeutic indications, are valueless; that diet is of minor importance.

Local therapy is the treatment of choice. Topical applications that keep the skin constantly dry and desquamating — the "chapping" treatment — is most favored. Careful "acne surgery" and X-ray treatment are also recommended. All agree that time, patience and attention to detail are essential. From another source comes word of a different approach to the solution of the problem. These investigators assumed as fact certain old fashioned, popular notions about the diseases: i.e., (1) that it is preponderantly one of puberty and adolescence; (2) that adjustments in sex hygiene by marriage or maturity often cure it; (3) that the Negro because of a more uninhibited sex life is practically free from it. Working on those assumptions, they made quantitative tests of sex hormones in 24 hour specimens of urine. They checked these against urine estimations of normal persons. Furthermore, knowing that both male and female hormones are present in the normal individual, they tested for relative percentages and their influence on the disease. From the accumulated data, they cautiously started treatment with antagonistic hormones. The results promise well for the future. It must be

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

emphasized, however, that the work is still in the experimental stage, with many questions still unanswered.

At the Manhattan meeting of the American Ear, Nose and Throat Society, Cone of St. Louis, reported that strips of salt pork were invaluable in controlling severe nosebleeds. In his experience, these plugs were more satisfactory than gauze, regardless of whether the bleeding was postoperative or incident to the onset of acute disease. He has found them easy to obtain, easier to introduce than the usual nasal pack, and except for some slight, early smarting, more comfortable for the patient. The strips keep well in brine and are free from trichinae.

* * * *

Pinworm infestation has been an annoying and troublesome condition to treat, and reinfection an all too frequent occurrence. Infusions of quassia, hypertonic salt enemas, mercurial ointments and diets have all helped to control the disease, but to be successful must be carefully done. At the present time, a simpler and more effective treatment is the use of medicinal gentian violet by mouth. The average dose for adults is 1 grain three times a day before meals for eight days. The treatment is then discontinued for one week to be repeated for another eight days if necessary. In children the dose per day is approximately one sixth of a grain at three years of age, increasing gradually to adult dosage for the older child. A small percentage of cases treated show some intolerance to the drug as evidenced by nausea, vomiting and diarrhea. Withholding the drug for a day or two usually clears it up. Best feature of this method is that all members of the family can be treated simultaneously with a minimum of inconvenience, thereby reducing the chances of reinfection.

* * * *

The occasional request for a reasonably safe and reliable depilatory can be met with the following formula. Strong: Strontium Sulfide 80.0 grams, Zinc Oxide 40.0 grams, Starch 40.0 grams, Menthol 0.6 grams. Mild: Strontium Sulfide 80.0 grams, Zinc Oxide 125 grams, Starch 150 grams, Menthol 1.0 grams. Mix with water into a thick paste and apply. Scrape it off after 5 to 8 minutes. Rinse with plenty of water then apply 0.5% citric acid. Dry thoroughly and apply cold cream and powder. With this technique, irritation is reduced to a minimum.

T.P.R., M.D.

Our Neighbors

MAINE

The Maine Medical Association lived up to its reputation for real hospitality at its annual meeting held at Rangeley Lakes in June. In spite of inclement weather, winter rules for golf, and cold fishless fishing the spirit of friendliness pervaded every gathering of the sessions. Doctor Tom Foster of Portland and an old Hartford Hospital intern was accorded the honor of election to the presidency of the Association for the coming year. It was a wise choice and should yield abundantly for the profession in Maine.

Doctor Hugh Cabot's pen has provoked many a scathing and bitter reply from all parts of this land of ours but none seems to be couched in better English nor hit the mark with more deliberateness than the article in the Journal of the Maine Medical Association (June 1940) entitled, "Of Making Many Books." Doctor Bliss of Bluehill is to be congratulated on his literary accomplishment. Here is a sample: "That an able surgeon stepping down from a trail pure and white with notable achievement should deliberately seek to blacken and smear the road over which the next generation of young men must travel, at least illustrates another way of bearing up under the strain of retirement. No penalty is severe enough for the unclean bird who literally befouls his own nest."

* * * *

NEW JERSEY

The Medical Service Plan of New Jersey, a voluntary insurance plan supported by the prepayment of subscriptions on an insurance basis, has been approved for operation during an experimental period in Essex County. Except for a minimum of necessary restrictions, this plan provides for the payment of a complete medical care program, adapted to persons of a selected, low income group.

Attendance at the annual meeting of the Medical Society of New Jersey this year was almost 700 or 18% of the membership. With over 700 at the annual meeting of the Connecticut State Medical Society the percentage was about 40.

* * * *

NEW YORK

Classification of physicians for military service has already begun in New York State, first steps being taken in relation to Workmen's Compensation in which the profession has classified itself. The Committee on Medical Defense for the Medical Society of the State of New York consists of S. J. Kopetzky of New York City, president-elect of the Society, as chairman; L. I. Bauer of Hempstead; and E. T. Wentworth of Rochester, all veterans of "World War No. 1."

Some three hundred and fifty physicians and pharmacists attended a joint meeting of the County Medical Societies of the Metropolitan area and the *Association for the Advancement of Professional Pharmacy* held at the Hotel Pennsylvania on May 28th. Speakers included Dr. Walter P. Anderton, President of the New York County Medical Society; Dr. Nathan B. Van Etten, President of the American Medical Association; Dr. Robert L. Swain, Past-President of the American Pharmaceutical Association; Dr. Evander F. Kelly, Secretary of the A.P.H.A.; Dr. Henry J. Vier, President of the Westchester County Medical Society, and others. Announcement was made of the establishment of the American College of Apothecaries, and a number of well known pharmacists were cited for distinguished service in the Association for the Advancement of Professional Pharmacy and for their efforts in organizing the American College of Apothecaries.

- NEWS -
from County Associations

Fairfield

The Stamford Medical Society held its Annual Dinner on June 13, at the Hubbard Heights Golf Club. Golf, and other outdoor sports occupied the afternoon with dinner at eight thirty in the evening.

On May 21, the members of the Stamford Medical Society had as their guest speaker Doctor Fenwick Beekman, Professor of Clinical Surgery at New York University. His subject was "The Management of Acute Appendicitis and Its Complications." The discussion was opened by Doctor John J. McCreery of Greenwich.

Doctor Ralph Crane, Vice-President of the Fairfield County Medical Society, reluctantly notes this sign of vanishing youth, having become the attending physician for the sixth generation of the same family.

The Scientific meetings for the current year of the Bridgeport Medical Association were brought to a close on June 4 with a most excellent discussion of "Periphal Vascular Disease" by Doctor Henry F. Faxon, assistant surgeon at Harvard University Medical School and Chief of the Vascular Clinic at the Massachusetts General Hospital. Doctor Faxon gave an excellent summary of the cases seen at his clinic over the past several years, with particular attention to Reynaud's disease, thromboangiitis obliterans, arteriosclerotic vascular disease and varicose veins. The local committee is to be congratulated on the splendid program which they outlined for the year on the ability of the speakers obtained for presentation of the various subjects.

The Bridgeport Medical Association held its annual outing at the Longshore Country Club on a pleasant 10th of July. The afternoon was

DRIP! DRIP! DRIP!

Doctors and surgeons everywhere are enthusiastic about the new "DryBrow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents each. (Extra utility: Some doctors use "DryBrow" golfing, others playing tennis). For sale at the Professional Equipment Company, New Haven.

devoted to feats of athletic prowess. Kegs of Mr. Schaeffer's beer were broached on the lawn close to the quoit throwers and another at the ninth hole on the golf course.

After an excellent dinner of steak and fixings Doctor Upton S. Reich presented awards as follows:

Golf prizes: To Roland T. Wehger for low net score. To Frank Turchik for the low gross. To Sidney Beck for the high gross.

Tennis prizes: *Singles*, Doctors Sprague and Reiter — were two all in the finals when the dinner bell rang. *Doubles*, Doctors Eddy and Reiter. Quoits: Doctors Havey and Creaturo, Horseshoes: Doctors Joseph Esposito and Cardone.

The annual outing of the Stamford Medical Society will be held Sunday, August 11. It will be in the form of a combined clam-bake and sheep-roast, and from all indications, will rival last year's gala affair, both in attendance and enthusiasm.

Russell A. Keddy has been made a diplomate of the American Board of Radiology. Doctor Keddy is the roentgenologist of the Stamford Hospital.

William H. Turnley has been elected a member of the American Rhinological, Laryngological, and Otological Society. The subject of his thesis leading to this election was "A Study of Bronchial Asthma in Relation to Foci of Infection of the Upper Respiratory Tract."

* * * *

Hartford

Doctor Stanley H. Osborn, State Commissioner of Health, was appointed a member of the Committee on Medical Preparedness and also Chairman of the Reference Committee on Sections and Section Work at the annual meeting of the House of Delegates of the A.M.A. held in New York City in June. Doctor Osborn's untiring efforts on behalf of progress in medicine have long been recognized in his own State. It is a satisfaction to all in the medical profession to see him thus honored.

Turning to that national pastime borrowed from the wily Scot, golf, it is very gratifying to learn that one of our own number, Doctor J. J. Hennessy, came home from the A.M.A. with the Golden State Trophy, secured by winning the eighteen hole championship. That should serve to encourage all of us for who doesn't have hopes?

The Hartford Board of Health has named Alfred L. Burgdorf, M.D., Health Officer to succeed Doctor Horning who recently resigned to accept a position with the American Public Health Association. In accepting this new position Doctor Burgdorf relinquishes his appointment as senior epidemiologist of the State Department of Health.

* * * *

Litchfield

A Committee representing the Litchfield County Medical Society met with representatives of the Charlotte Hungerford Hospital on July 10 to discuss a plan for the collection and preservation of medical material of historic interest. It is planned that such material as may be of value from a historical standpoint, will be ultimately assembled at the Charlotte Hungerford Hospital where it will be readily accessible to persons interested in it. Representatives from the hospital were, President Francis H. Griffiths, Doctors H. B. Hanchett, F. A. Sutherland, W. B. Walker and Albert W. Buck, Director of the hospital. Representatives of the Litchfield County Medical Society were Doctors Arthur H. Jackson, Chairman, Charles H. Turkington and Frederic W. Wersebe.

Doctor and Mrs. John F. Kilgus have just returned from Owl's Head Harbor, Lake Champlain, Vermont, where they spent some days enjoying fishing in the lake.

Doctor and Mrs. Francis A. Sutherland recently spent two weeks in southwestern Virginia visiting relatives of the families of both Doctor and Mrs. Sutherland.

Doctor and Mrs. Emerson S. Hill are leaving early in August for a month's vacation at Higgins Beach, Maine. Doctor and Mrs. Hill have been regular visitors at Higgins Beach for a number of years.

Doctor T. M. Ryan is traveling in the Middle West. During his absence he will visit several of the important Medical Centers of that region.

* * * *

Windham

Doctor Ralph Gilman, Secretary of the Windham County Medical Association, was inducted into the American College of Physicians at its recent session in Cleveland.

SPECIAL NOTICES

EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday January 4, 1941, at 2:00 P.M. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

The following action regarding case records to be submitted by candidates taking the Group B, Part I, examination was passed by the Board at its annual meeting in Atlantic City, N.J., on June 6, 1940: "Case records submitted by candidates must be of patients treated within four years prior to the date of the candidates' application. The number of cases taken from one's residency service should not be more than half (25) of the total number of fifty (50) cases required."

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's Office not later than October 5, 1940.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, immediately prior to the June 1941 meeting of the American Medical Association.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6) ,Pennsylvania.

TRAINING REQUIREMENTS

In response to numerous inquiries regarding special training requirements, the Board desires again to announce that there are three methods of meeting these requirements for admission to the Board examinations. First by the residency system; second, by the partial residency and partial assistantship method; and third, entirely by the assistantship or "preceptorship method." Details of the residency requirements are given in the Board booklet. The Board will accept in lieu of the formal residency service the training acquired by a candidate serving on an assistant or dispensary staff of an obstetrical and gynecological division of a recognized Hospital, under the direction of a recognized obstetrician-gynecologist (preferably a Diplomate.) The time required for this type of training, must be longer than with the formal, more intensive residency type of training, and the allowance of time depends upon the duties and responsibility given the candidate. Applicants lacking all formal special training should have a minimum of five years of hospital clinic, or assistant staff appointments in the specialty, under approved direction. Teaching appointments without accompanying hospital staff or clinical appointments will not satisfy the Board requirements. A special form amplifying the original application must be filled out to cover the details of such assistantship, or preceptorship type, of training. The Board approves for special training, work done in institutions approved jointly by the Board and by the Council on Medical Education and Hospitals of the A.M.A.

* * * *

ANNUAL MEETING OF EYE AND EAR SPECIALISTS

The American Academy of Ophthalmology and Otolaryngology will hold its forty-fifth annual convention in Cleveland, October 6 to 11, with headquarters at the Hotel Cleveland.

The Academy, an organization of more than 2,500 specialists in diseases of the eye, ear, nose and throat. carries on an active program of education for its members. In addition to scientific papers, an elaborate series of courses is presented at each convention to bring the members up to date in their chosen fields. More than 100 of these teaching lectures will be offered this year.

In the past year arrangements have been made to extend the teaching activities to young physicians just entering on specialization. Home study courses are being prepared for any of these young men who wish to take them and their work will be supervised by members of the academy interested in improving the caliber of specialists in practice.

The Cleveland meeting will be noteworthy in several respects.

The Academy will honor Dr. Secord H. Large, Cleveland, who this year completes thirty years as comptroller of the organization. Dr. Large as the honor guest of the meeting will receive many special distinctions.

Immediately following the Academy meeting, there will be a Pan-American Congress of Ophthalmology, October 11 and 12, which eye specialists from all the Latin American countries are expected to attend.

Dr. Frank Brawley, Chicago, is president of the Academy and Dr. Frank R. Spencer, Boulder, Colo., is president-elect. Vice presidents are Drs. Arthur W. Proetz, St. Louis: Joseph F. Duane, Peoria, Ill., and Charles T. Porter, Boston. Dr. William P. Wherry, 1500 Medical Arts Building, Omaha, is executive secretary.

* * * *

ANNOUNCEMENT OF A STUDY TO EVALUATE ORIGINAL SEROLOGIC TESTS FOR SYPHILIS

More than five years ago the Committee on Evaluation of Serodiagnostic Tests for Syphilis, in cooperation with the United States Public Health Service, conducted a study to evaluate original serologic tests for syphilis or modifications thereof in the United States. The results of this study were published shortly after the investigation was completed.[1]

Consideration is now being given by the Committee to the organization of a second evaluation study of original serologic tests for syphilis or modifications thereof within the next year. If the need for an investigation of this kind seems to justify the cost, invitations will be extended to the authors of such serologic tests who reside in the United States, or who may be able to participate by the designation of a serologist who will represent them in this country. The second evaluation study will be conducted utilizing methods comparable to those employed in the first study.[2]

Serologists who have an original serologic test for syphilis or an original modification thereof and who desire to participate in the second evaluation study should submit their applications not later than October 1, 1940. The applications must be accompanied by a complete description of the technic of the author's serologic test or modification. All correspondence should be directed to the Surgeon General, United States Public Health Service, Washington, D. C

---

1. Ven. Dis. Inform., Washington. June 1935, 16: 189. J.A.M.A., Chicago. June 8, 1935, 104: 2083.
2. J.A.M.A., Chicago. Dec. 1, 1934, 103: 1705.

* * * *

AMERICAN CONGRESS OF PHYSICAL THERAPY TO CONDUCT INSTRUCTION COURSE MORNINGS THROUGHOUT ANNUAL SCIENTIFIC SESSION TO BE HELD IN CLEVELAND, OHIO

The 19th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 2 to 6th, inclusive, at Hotel Statler, Cleveland, Ohio. This year there will be a departure from the usual arrangements in that the mornings will be devoted to an instructional seminar with the scientific program presented afternoons and evenings. This enables physicians to economize on time by attending both the instruction course and the annual convention during the same week. The entire instruction schedule is elective in character. Registrants may pursue only the individual courses they desire. The complete course consists of twelve lectures from a diversified list of forty-eight. The scientific program itself consists of papers, demonstrations and motion pictures covering every branch of physical therapy. There will be a separate scientific program covering Eye, Ear, Nose and Throat subjects. Write for schedule, fees, etc., to the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Ill.

The A. M. A. sent you a questionnaire. What did you do with it?

• Quarto Notes •

PRINCIPLES OF SURGICAL CARE

by

SHOCK AND OTHER PROBLEMS

Alfred Blalock, M.D., Professor of Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.

325 pages $4.50
St. Louis C. V. Mosby Co. 1940

Periodically the surgeon must pause to take account of his stock in trade, to replace obsolete with new methods which have proven their value, and to review his own ideas of surgical care in the light of present knowledge. To aid at such a time Doctor Blalock's volume should prove of almost inestimable value. It would be difficult to find a book of its size which covers the subject at hand in a more comprehensive and pertinent manner. Every surgeon could well afford to spend a few hours studying its contents.

"Principles of Surgical Care" represents an extension and amplification of the Beaumont Lectures for 1940, one of a series of physiological monographs inaugurated in 1922 as a tribute to one of Connecticut's own, William Beaumont. As the author informs us, this monograph originally was intended to deal only with a consideration of shock or peripheral circulatory failure, but this soon was found impossible without including a discussion of many abnormalities which may have contributed to the development of the condition. Hence, we find in this volume a discussion of anesthesia, fluid balance, acid base disorders, and nutritional disturbances, as well as postoperative pulmonary, abdominal, urinary and other complications.

The author stresses the importance of making the patient's initial impression of the hospital as pleasant as possible. His chapter on "Anesthesia and Anesthetic Agents" is up to date and helpful. Many details in surgical technique and the treatment of wounds are included which have been found of value and which are extremely important.

The chapter on shock occupying about one-third of the volume is an excellent one and contains a discussion of the treatment of burns. Reference is made to the tannic acid tub treatment introduced by Doctor Donald B. Wells of Hartford. Fluid balance is dealt with carefully and illustrations are included to make the text more readily understood. The few pages on nutritional disorders deal with hypo-proteinemia and the vitamin deficiences. There is up to date information on the management of the surgical patient with diabetes, with hypertension and with nephritis. In the treatment of postoperative complications the distinction between pulmonary atelectasis and pneumonia is clearly defined, and the use of oxygen and the Miller-Abbott tube in abdominal complications are outlined.

Each chapter contains an excellent bibliography, a valuable aid to the student of surgical shock.

THE EVOLUTION OF OBSTETRIC ANALGESIA

by

Andrew M. Claye, M.D., (Leeds), F.R.C.S. (Eng.), F.C.O.G., Leeds, Eng., Professor of Obstetrics and Gynecology, University of Leeds; Honorary Surgeon, Leeds Maternity Hospital, and Hospital for Women; with a chapter by W. Stanley Sykes, M.A., M.B., B.Ch. (Cantab.), D.A., Leeds, Honorary Anesthetist, General Infirmary and Hospital for Women

103 pages $2.00
London Oxford University Press 1939

This small volume, which is divided into six chapters, deals chiefly with the introduction of ether and chloroform into obstetrics and the development of twilight sleep. The author, who is an obstetrician, has apparently written this text for the obstetrician and not for the anesthetist. Chapter I, perhaps the most enjoyable chapter to read, gives an historical account of the introduction of ether and chloroform into obstetrics by Simpson. A further comparison is made between these two agents in regard to the advantages and disadvantages as analgesics as well as anesthetic agents.

The second chapter deals with scopolamine-morphine and the technique of producing twilight sleep by the method developed by Gauss. The interesting features of this portion of the text are the discussions of the criteria necessary for establishing successful amnesia and the oligopnea of the newborn.

Chapter III has been written by W. Stanley Sykes, anesthetist to the General Infirmary at Leeds. He very briefly discusses the signs and symptoms of analgesia, the different types of machines for the administrátion of agents and the use of nitrous oxide, ethylene, cyclopropane, and vinyl ether for obstetrical analgesia.

Amnesia produced by scopolamine is elaborated upon further in Chapter IV. The author gives the results of his personal experience with scopolamine at Leeds Maternity Hospital.

Chapter V is concerned with the use of some barbiturates administered either alone or in combination with other agents such as chloral hydrate or scopolamine. Again the author gives the results of his personal experience with these agents.

The last chapter is a brief discussion of the ill effects of fear and apprehension on the parturient woman. He pleads for more widespread and better analgesia during labor. The author states that the ideal analgesic drug for midwifery has not yet been found and he concludes by saying, "I have an idea that it will prove to be one of the maligned barbiturates, perhaps still hidden in the womb of time."

Summary

This book has been written by an obstetrician who has had considerable experience with obstetrical analgesia. It will be of more value to the obstetrician than to the the anesthetist. It will, undoubtedly, serve its purpose in bringing to the reader's attention the need for better analgesia during labor.

R. B. Sommerfield
R. M. Tovell

CLINICAL HEART DISEASE

by

Samuel A. Levine, M.D., F.A.C.P.

477 pages Second edition $6.00
Philadelphia and London W. B. Saunders Co. 1940

In the preface to the first edition Dr. Levine wrote:—"The purpose of this book is to present in a simple form the important aspects of the diagnosis, prognosis and treatment of heart disease." He has perpetuated this plan of presentation in the second edition.

Little revision has been necessary since the first appearance of the book four years ago. Some new electrocardiographic studies have been added; also, an analysis of the nature of heart failure and digitalis action. A discussion has been included on the relation between trauma and heart failure.

This is a splendid book. Written by one of the leading spirits in the field of cardiology, it is invaluable as an addition to any medical library.

"Clinical Heart Disease" is not for physicians interested only in cardiology. It should be read by everyone who treats the sick. The heart, more than any other organ, beats its way into the field of every medical or surgical specialty. No tissue can long remain unaffected by the degree of functional power of the heart.

Dr. Levine writes in simple yet comprehensive style. To have read this volume is to have sat down and talked informally with the author about diseases of the heart.

P. J. Steincrohn

* * * *

SEX IN MARRIAGE

by

Ernest R. Groves, Professor of Sociology, University of North Carolina

and

Gladys H. Groves, Director of the Marriage and Family Council, Inc., Chapel Hill, North Carolina

250 pages Second edition, revised $2.00
New York Emerson Books, Inc. 1940

This is an excellent book to place in the hands of any young person who may be contemplating marriage. It contains much information that is taught in our colleges today and, in addition, some of the more intimate knowledge pertaining to sex that should be acquired by the husband or wife of tomorrow. Presented as the material is in a clear and sane manner, it should not fail to be interesting to the earnest reader.

There is much in this volume for the married couple who is finding difficulty from sex maladjustment, whether it be in early years or in middle life. As the authors state in their preface, "from every quarter comes criticism of marriage and modern family life," and so they have attempted to be of help to husband and wife by explaining facts, which until a few years ago, were rarely considered suitable topics for conversation, least of all for publication. One of the chapters deals in a very sane way with the subject of birth control. No physician who comes in contact with the problems of married life but will profit by a fairly careful perusal of this book.

Charter and By-laws
Connecticut State Medical Society

AN ACT REVISING THE CHARTER OF THE CONNECTICUT MEDICAL SOCIETY AND CHANGING ITS NAME TO THE CONNECTICUT STATE MEDICAL SOCIETY

General Assembly

January Session, A.D., 1939

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suit of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal, to an amount not exceeding one hundred thousand dollars.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismission and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all moneys and other property belonging to the corporation in such manner as it may deem advisable to promote the objects and interests of the society and in general to make such by-laws and regulations for the due government of the society, not repugnant to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of The Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society; (2) delegates to be elected annually as hereinafter provided, by the several county medical associations in this State which heretofore have been and are affiliated with The Connecticut State Medical Society and (3) eight councillors to be elected from time to time as hereinafter provided.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held during the month of May in each year and upon such day in said month as The House of Delegates shall, from time to time, prescribe.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation in each year, every affiliated county association shall elect a delegate or delegates to represent it in "The House of Delegates" of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in "The House of Delegates," one councilor from each affiliated county medical association. The councilors holding office at the time of the passage of this act shall serve out the terms of office for which they were elected. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham and Middlesex shall each elect one councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield and Tolland counties shall each elect one councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 7. The secretary of each affiliated county medical association in this state shall, within ten days following any meeting of such association at which new members are elected, file with the secretary of the society a list of all members of such association who are at the time in good and regular standing and thereupon all such persons shall become members of The Connecticut State Medical Society without further action.

Approved April 13, 1939 (Special Act 252, 1939.)
General Assembly

BY-LAWS

Chapter I

Section 1. Name. The name and title of this organization shall be The Connecticut State Medical Society.

Section 2. Purposes of the Society. The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Connecticut, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members, and to protect them against imposition; to enlighten and direct public opinion in regard to the great problem of State medicine, so that the profession shall become more capable and honorable within itself and, more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

Section 3. Component Associations. Component Associations shall consist of those county medical associations which heretofore have been and now are affiliated with The Connecticut State Medical Society.

Section 4. Composition of Society. This Society shall consist of members, delegates, guests, and honorary members.

Section 5. Members. Members of this Society shall be members of the component county medical associations.

Section 6. Delegates. (1) Delegates shall be those members who are elected by the component county associations; (2) the Councilors of their respective component associations in the House of Delegates of this Society.

Section 7. Guests. Any distinguished physician not a resident of this State who is a member of his own State Association, may become a guest during any annual session on invitation of the officers of this Society and shall be accorded the privilege of participating in all the scientific work for that session.

Section 8. Honorary members. Eminent physicians may be elected Honorary Members by a major vote of the House of Delegates after nomination of one year, but shall not exceed three in any one year.

Honorary Members shall have all the privileges accorded by Section 7 to guests.

Chapter II. Membership

Section 1. The name of a physician upon the properly certified roster of members of a component association, who has paid his annual assessment, shall be prima facie evidence of membership in this Society.

The annual tax shall be collected from all such members except the secretaries of the County Medical Associations. *Members who have been in good standing in the Society for forty consecutive yeras or who have attained the age of sixty-eight and shall have been members of the Society for fifteen years immediately preceding, shall upon written request addressed to the Treasurer of the Society, be exempted from the further payment of dues and will continue as active members of the Society enjoying all rights and privileges.* The tax of any member may be remitted by majority vote of the House of Delegates upon recommendation of any County Medical Association.

Section 2. Any person who is under sentence of suspension or expulsion from a component association, or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of the Society, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Section 3. Each member in attendance at the annual session shall enter his name on the registration book, indicating the component association of which he is a member.

Chapter III. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Society, and shall consist of (1) the President, President-Elect, Treasurer and Secretary of the Society; (2) Delegates elected by the component county medical associations; and (3) the Councilors.

Section 2. The House of Delegates shall meet on the first day of the annual session. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General Meetings. The order of business shall be arranged as a separate section of the programme.

Section 3. Each component association shall be entitled to send to the House of Delegates each year, one delegate for every thirty-five members, or any part of that number.

Section 4. Fifteen delegates shall constitute a quorum.

Section 5. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Society, and shall constantly strive to make each annual session a stepping-stone to further advancement

Section 6. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 7. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interests in such county associations as already exist and for organizing the profession in counties where associations do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every physician in every county in the State who can be made reputable has been brought under medical society influence.

Section 8. It shall encourage post-graduate and research work, as well as home study, and shall endeavor to have the results discussed and utilized.

Section 9. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-laws of that body.

Section 10. It shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates.

Such committees shall report to the House of Delegates and may be present and participate in the debate on their reports.

Section 11. It shall approve all memorials and resolutions issued in the name of the Society before the same shall become effective.

Section 12. Sections and District Societies. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections and for the organization of such Councilor District Associations as will promote the best interests of the profession, such associations to be composed exclusively of members of component county associations.

Chapter IV. Sessions and Meetings

Section 1. The Society shall hold an annual session during which there shall be held daily General Meetings which shall be open to all registered members, guests and honorary members.

Section 2. The time and place for holding each annual sess on shall be fixed by the House of Delegates.

Section 3. Special meetings of either the Society or the House of Delegates may be called by the President or the Council and shall be called by the President on petition of 10 members of the House of Delegates or 50 members of the Society.

Section 4. General Meetings. All registered members may attend and participate in the proceedings and discussions of the General Meetings and of the Sections. The General Meetings shall be presided over by the President or by one of the Vice-Presidents, and before them shall be delivered the address of the President and the orations.

Section 5. The General Meeting may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and the public.

Chapter V. Officers

Section 1. The Officers of this Society shall be a President, a President-Elect, two Vice Presidents, a Secretary, a Treasurer and eight Councilors.

Section 2. The officers, except the Councilors, shall be elected annually. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham and Middlesex shall each elect one Councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield and Tolland counties shall each elect one Councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall biennially elect a Councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs by election to fill the unexpired portion of the term.

Section 3. All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

Section 4. No person shall be elected to any such office who has not been a member of the Society for the past two years.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all meetings of the Society and of the House of Delegates; shall appoint all committees not otherwise provided for, shall deliver an annual address at such times as may be arranged, and perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and, as far as practicable, shall visit by appointment the various sections of the State and assist the Councilors in building up the county associations and in making their work more practical and useful.

Section 2. At the Annual Meeting in 1937, and at each Annual Meeting thereafter, the Council shall nominate to the House of Delegates, a President-Elect who shall become the President of the Society at the conclusion of the Annual Meeting of the next following year without further formality. The duties of the President-Elect shall be to aid and assist the President in any way designated by him, to familiarize himself with the activities of the Society, and to attend the meetings of the Council and take part in its deliberations but without vote.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of the President's death, resignation, or removal, the Council shall select one of the Vice-Presidents to succeed him.

Section 4. The Treasurer shall give bond in the sum of $5,000, the manner of bonding to be left to the Council. Except as otherwise provided, he shall demand and receive all funds due the Society, together with the bequests and donations and he shall pay money out of the treasury only on a written order of the President, countersigned by the Chairman of the Council; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings for the previous fiscal year and of the state of the funds in his hands at the close of each fiscal year. The Treasurer is authorized to advance periodically to the Executive Secretary and to the Scientific Secretary and Editor of the Journal prorated portions of the funds allocated to the offices of the Executive Secretary and the Journal for the operation of the offices of the Executive Secretary and the Journal as provided in the approved budget. The Executive Secretary and the Editor of the Journal are authorized to make payments of necessary expenses for the activities of those offices from such prorated portions of the budgeted amounts received from the Treasurer, and the Executive Secretary and the Editor of the Journal shall render an accounting of such expenditures to the Treasurer from time to time as he may request, and a report of such expenditures for the year shall be consolidated with the report of the Treasurer presented to the House of Delegates at the Annual Meeting each year.

Section 5. The Secretary shall attend the General Meetings of the Society and the meetings of the House of Delegates and shall keep minutes of their respective proceedings in separate record books. He shall be ex-officio Secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates of the annual sessions. He shall, with the cooperation of the Secretaries of the component associations, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall aid the Councilors in the organization and improvement of the county associations and in the extension of the power and usefulness of this Society. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointment and duties. He shall employ such assistants as may be ordered by the House of Delegates. He shall supply each component association with the necessary blanks for making their annual reports. Acting with the Program Committee he shall prepare and issue all programmes. The amount of his salary shall be fixed by the Council.

Chapter VII. Council

Section 1. The Council shall consist of one Councilor from each county and the President, the President-Elect, the Secretary, the Treasurer, the Editor of the *Journal* and the *Delegates to the American Medical Association.* It shall be the Finance Committee of the House of Delegates. Five Councilors shall constitute a quorum.

The Board of Councilors shall appoint from its own members two members who, with the Treasurer of the Society, shall constitute a sub-committee to be designated a Committee on the Permanent Funds, whose duty it shall be to advise on the investment of such funds as the Society may have or receive by bequest or donation, according to the laws of the State of Connecticut governing trust funds. This committee shall, through the Chairman of the Council, recommend to the House of Delegates the disposition to be made of the permanent funds, both principal and income.

Section 2. The Council shall meet daily during the session, and at such other times as necessity may require, subject to the call of the chairman or on petition of three Councilors. It shall meet on the last day of the annual session of the Society to organize and outline work for the ensuing year. It shall elect a chairman and a clerk, who, in the absence of the Secretary of the Society, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates.

Section 3. The Board of Councilors shall constitute the nominating committee of the Society. They shall report as such to the House of Delegates during the first session of the general session. After the report has been submitted an opportunity shall be given for other nominations to be made.

Section 4. Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component associations where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county associations and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district at the annual session of the House of Delegates.

Section 5. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Section 6. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. As the Finance Committee, it shall annually audit the accounts of the Treasurer and Secretary and other agents of this Society, and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of this Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of the Secretary or the Treasurer, the Council shall fill the vacancy until the next annual election.

Section 7. The Council shall serve as a Board of Review for cases of claimed malpractice as may be referred to it by any component County Association's Committee on Medical Ethics and Deportment.

Chapter VIII. Committees

Section 1. The standing committees shall be as follows:

A Program Committee.

A Committee on Public Policy and Legislation.

A Committee on Medical Examination and Medical Education.

A Committee on Honorary Members and Degrees.

A Committee on Arrangements, and such other committees as may be necessary. Such committees shall be elected by the House of Delegates unless otherwise provided.

A Committee on Public Relations.

A Committee on the Clinical Congress.

A Committee on Industrial Health.

Section 2. The Program Committee shall consist of three members which shall be nominated by the Council and elected by the House of Delegates. At the annual meeting of the House of Delegates in 1938 the Council shall nominate one member of the Society to serve as a member of the Program Committee for three years, one member to serve as a member of the Committee for two years, and one member to serve as a member of the Committee for one year. Annually thereafter the Council shall nominate to the House of Delegates one member of the Society to serve as a member of the Program Committee for three years. The Council shall designate the chairman of the Committee. The duties of the Program Committee shall be to arrange the scientific program for the meetings of the Society and it shall prepare such program for the Annual Meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Section 3. The Committee on Public Policy and Legislation shall consist of one member from each component association, and the President and Secretary and the Committee on National Legislation. Under the direction of the House of Delegates it shall represent the Society in securing and enforcing legislation in the interest of the public health and scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local, state, and national affairs and elections.

Section 4. The Committee on Medical Examination and Medical Education shall consist of five members who shall be appointed in accordance with the statutes of the State of Connecticut. The committee shall conduct the medical examination of candidates for certificates of qualifications for license to practice medicine in the State in accord with the requirements of the Medical Practice Act. It shall annually present a written report to the House of delegates. The committee shall also be a committee on medical education and shall cooperate with the council of education of the American Medical Association in the effort to elevate the standard of medical education in the United States.

Section 5. The Committee on Honorary Members and Degrees may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in this Society. Such candidates may be elected honorary members in accordance with the provisions of Chap. I, Section 8 of the By-laws.

Section 6. The Committee on Arrangements shall be appointed by the component association in which the annual session is to be held. It shall provide suitable accommodations for the meeting places of the Society and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Secretary for publication in the programme, and shall make additional announcements during the session as occasion may require.

Section 7. At the Annual Meeting in 1938 and annually thereafter, the Council shall nominate to the House of Delegates one member of each component county association to serve for the period of one year on the Society's Committee on Public Relations. The chairman of this Committee shall be designated annually by the Council. The duties of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine. If the Committee so desires, its deliberations and conclusions may be reviewed and passed upon by the Council of the Society, but such approval shall not be mandatory.

Section 8. The Council shall nominate to the House of Delegates each year a Committee on the Clinical Congress and designate a Chairman, a Secretary and a Treasurer of the Committee. The function of the Committee shall be the arrangement and direction of the annual Clinical Congress of the Society and such other activities in post graduate instruction as may from time to time appear desirable to the Committee. The Chairman, the Secretary and the Treasurer shall be the trustees of the funds of the Clinical Congress and this Committee, through its Treasurer, shall receive income from registration fees of the Congress and other sources as may attend the administration of the Congress, and pay therefrom all necessary expenses. This fund shall be known as the Clinical Congress Fund and shall be retained in the hands of the Treasurer of the Clinical Congress, shall be audited by the Society's auditors and a report of the transactions of the fund for the fiscal year shall be rendered by the Treasurer of the Society to the House of Delegates each year at its annual meeting. The Treasurer of the Clinical Congress shall be bonded by a corporate surety in the sum of five thousand dollars, the premium on such bond to be paid from the Clinical Congress Fund.

Section 9. The Council shall nominate to the House of Delegates each year one member from each County Association to be a member of the Committee on Industrial Health and designate the Chairman of this Committee. The function of the Committee on Industrial Health shall be to inquire into the health hazards of industry with the view of making information on the subject available to members of the Society and improving the health and hygiene of persons employed in industry.

Chapter IX. Funds and Expenses

The fiscal year of the Society shall terminate on December 31st of each year.

Funds shall be raised by an equal per capita assessment on each component association, except that members elected to the County Associations at the semi-annual meetings in October will be assessed one-half of the annual dues for the year of their election. The amount of the annual assessment per member shall be fixed by the House of Delegates.

Funds may also be raised by voluntary contributions, for the Society's publications, and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society, for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Finance Committee before action is taken thereon.

All funds of the Society by whomever held shall be deposited promptly upon receipt in a state or national bank located in the State of Connecticut.

Chapter X. Referendum

Section 1. A General Meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such questions to the members of the Society who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Section 2. The House of Delegates may, by a two-thirds vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

Chapter XI. County Associations

Section 1. All County Associations now in affiliation with the Connecticut State Medical Society shall be component parts of this Society.

Section 2. Each County Association shall judge of the qualifications of its members, but as such associations are the only portals to this Society and to the American Medical Association, all reputable and legally registered physicians, except those who practice or claim to practice or lend support to any exclusive or irregular system of medicine, shall be entitled to membership.

No physician shall be admitted to or retain membership in a County Medical Association after the expiration of his present contract who has agreed to furnish medical services to any organization or union for a stipulated sum per member, or for other consideration than the regular local fee for such services.

Section 3. Any County Medical Association may suspend or expel any member who is guilty of improper or unprofessional conduct, by a two-thirds vote of the members present and voting at any regular meeting, provided due notice has been given on the programme of said meeting at least ten days before its session. When from any cause a member of the Connecticut State Medical Society ceases to be a member of one of the component county medical associations, his membership in the Connecticut State Medical Society shall terminate, but any physician who may feel aggrieved by the action of the association of his county in refusing him membership or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Section 4. In hearing appeals the Council may admit oral or written evidence as in its judgment will be best and to most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 5. When a member of a component association in this state or any component association of the American Medical Association removes to another county in this state or takes up his residence within this state and presents a certificate signed by the president or secretary of the component association stating that he is a member in good standing and evidence that he is legally qualified to practice medicine in the State of Connecticut, he may, upon recommendation of the Committee on Credentials, be elected to membership in a component association of this Society by a two-thirds vote of the members voting.

When a physician applies for membership, or when an application is made to be received on transfer from another state, the secretary of the component association shall forward the applicants name and address to the biographic department of the American Medical Association for such information as may be on file relative to his record. Printed forms for this purpose will be furnished by the Secretary of this Society. After the adoption of this By-law, no new member shall be enrolled or accepted on transfer from another state until this provision shall have been carried into effect.

Section 6. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the association in whose jurisdiction he resides.

Section 7. Each component association shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral, and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the Society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 8. At some meeting in advance of the annual session of this Society, each county association shall elect a delegate or delegates to represent it in the House of Delegates of this Society in the proportion of one delegate to each thirty-five members, or any part of that number, and the Secretary of the Association shall send a list of such delegates to the Secretary of this Society at least twenty days before the annual session.

In the case of death, illness or disability of a delegate, the President of the County Association in which the vacancy occurs shall appoint a substitute delegate, with full power to represent his county during the delegate's disability, or until the successor of such appointee is elected at the next meeting of the County Medical Association. Any vacancy in the office of Councilor may be filled by the County Association of the County in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 9. The Secretary of each component association shall keep a roster of its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of registration in this State, and such other information as may be deemed necessary. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 10. The dues of the Society shall be due and payable on January 1 of each year.

The Secretaries of the component county associations shall be charged with the collection from the members of their associations, the dues assessed by this Society. Bills for such dues shall be rendered to all members immediately following the first January of each year, and the Secretaries of the component county associations shall forward to the Treasurer of this Society on or before the 10th of each month, all monies collected by them and due the Treasurer of the Society.

Section 11. The several county medical associations shall have power to adjourn; to call special meetings, as they shall deem expedient; and to adopt such by-laws as they find desirable, not contrary to the laws of this State or the charter and by-laws of the Connecticut State Medical Society.

Chapter XII. Miscellaneous

Section 1. No address or paper before this Society, except those of the President and orators, shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes, nor more than once on any subject except by unanimous consent.

Section 2. All papers read before the Society or any of the Sections shall become its property. Each paper shall be deposited with the Secretary before reading. No paper shall be read before this Society which has been previously published or read before any other organization.

Section 3. The deliberations of this Society shall be governed by parliamentary usage as contained in Roberts' Rules of Order, when not in conflict with the charter and by-laws.

Section 4. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XIII. Amendments

These By-laws may be amended at any annual session by a majority vote of all delegates present at that session, after the amendment has been laid on the table until the next annual session. If however, the proposed alteration has been published in the notice of the session, it may be acted upon after it has laid on the table one day.

"OSLER AT OLD BLOCKLEY"

"Osler at Old Blockley" a painting in oil by Dean Cornwell, was unveiled at the dedication of the Osler Memorial Building on the grounds of the Philadelphia General Hospital this past June and was later exhibited at the American Medical Association convention in New York.

The painting depicts one of Osler's outstanding contributions to medicine, namely, bringing medical students to the bedside of the patient for clinical study. In the painting Osler is shown at the side of an elderly patient on the hospital grounds. Surrounding Osler and the patient are internes who have stopped with him as they were on their way to the autopsy house to observe one of his famous post mortems. This autopsy house, now the only Osler Memorial Building in the United States, is shown in the background. This memorial was made possible by a grant from John Wyeth & Brother.

"Osler at Old Blockley" is the second painting in the series "Pioneers of American Medicine" sponsored by John Wyeth & Brother as part of a project to highlight the contributions of Americans to the advancement of medicine. "Beaumont and St. Martin" was the first painting in the series.

Colored reproductions of "Osler at Old Blockley," suitable for framing may be obtained free by addressing requests to Connecticut State Medical Journal, 54 Church Street, Hartford, Connecticut.

MEDICAL PREPAREDNESS SURVEY OF THE A.M.A. GETS UNDER WAY

"In response to a request from the Surgeon Generals of the Army, Navy and Public Health Service the American Medical Association has set its machinery in motion to secure information relative to the availability and qualifications of professional personnel for service in the federal preparedness program," Irvin Abell, M.D., Louisville, chairman of the Committee on Medical Preparedness of the Association, declares in an appeal for service addressed to the profession and published in the Medical Preparedness Section of *The Journal* of the Association for June 29.

"Since mental and physical health is of fundamental importance in the prosecution of such a program," Dr. Abell says, "the doctor, with a knowledge of the measures essential to the conservation of health, the prevention and cure of disease, is in a position to make a signal contribution to its success. The medical profession, actuated by a high sense of patriotism and civic responsibility, has freely proffered its help in every emergency with which the government has been confronted. The American Medical Association has always unfailingly placed its facilities at the disposal of the constituted authorities. During the first world war 32,000 of its members voluntarily served with the armed forces and many more thousands participated in various helpful capacities. Soon a letter and a schedule will reach you on which you may supply information necessary to enable our nation, in an emergency, to call on physicians for the services they are best equipped to render. The reply of the profession to this call for help will by its generosity and spontaneity demonstrate that medical men continue to be not unmindful of the obligations which intelligent citizenship entails and as well not only their willingness but their determination to fulfill them."

PHYSICIANS NEEDED FOR ARMY SERVICE

The physician, like every other American, has become actively interested in our national security and stands ready to contribute his services as required for military preparedness.

The immediate problem in this connection is one that concerns the War Department, and primarily the young physician. The War Department must procure sufficient additional personnel from the medical profession to augment the medical services of the Regular Army as the various increases are made in the strength of the Regular Army, as authorized by Congress to meet the partial emergency. The young physician is especially concerned because it is usually advantageous, and is often more convenient for him to serve with the Army.

Present plans of the War Department are designed to make service attractive and instructive for the young physician. If the physician holds a Medical Corps Reserve commission he can be ordered to active duty if he so requests. If he does not hold a commission, but is under 35 years of age and is a comparatively recent graduate of an accredited school, he may secure an appointment in the Medical Corps Reserve for the purpose of obtaining extended active duty for a period of one year or longer. Duty is given at General Hospitals, Station Hospitals, and with Tactical Units, and embraces all fields of general and specialized medicine and surgery. Excellent post-graduate training is obtainable in connection with Aviation Medicine. After serving 6 months of active duty in the continental United States, a Reserve officer may request duty in Hawaii, Panama, or other United States territories and possessions. The initial period for duty is for one year and yearly extensions are obtainable thereafter until the international situation becomes more clarified and our domestic military program becomes stabilized.

Many young doctors who have served with the Army on extended active duty have taken the competitive examination for entrance into the Medical Corps of the Regular Army. Extended active duty affords an excellent opportunity for the physician to observe modern military medicine and the facilities that exist for a complete and comprehensive medical practice.

Pay is according to rank, and, including subsistence and quarters allowances for an officer with dependents, amounts to an annual sum of $3,905 for a Captain and $3,152 for a First Lieutenant; or, without dependents, to an annual sum of $3,450 for a Captain and $2,696

Prescribed for the Professional Palate

There's no whisky to please your palate more completely than Johnnie Walker. For there's no finer whisky than Scotch, and Johnnie Walker is Scotch at its smooth, mellow best.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820
...still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE
Wyeth
HAS SHOWN A CONVINCING RECORD* OF EFFECTIVENESS IN ACUTE ANTERIOR URETHRITIS
due to Neisseria gonorrheae • Trichomonas vaginalis
Monilia albicans

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in anterior urethritis: Wyeth's Silver Picrate Crystals in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genitourinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

for a First Lieutenant. In addition, reimbursement is made for travel to duty station and return.

Further information may be obtained by writing to The Surgeon General, U.S. Army, Washington, D.C.

* * *

CLINIC

Your name? Your age?
Where do you live?
Your height? Your weight?
Yes, you must give
Your mother's name,
Your father's name,
Your brother's name.
Your work? Your wage?
Your boss? Your shop?
Here put an X
Right at the top
It means you're poor,
That's all; sit down
And wait, you're poor.
Doctor? No,
Sit down, no hurry.
Come? He'll come
Sometime, don't worry.
Time? It's eight.
Time? It's nine.
Time? It's ten.
Time? It's time.
Your name? Your age?
Hurt much? Hurt here?
Say ahhh, relax;
Lean back, draw near,
Say ahhh, breathe out —
And out — and in —
Go home? No, wait,
The nurse must have
Some facts. Please state
Your middle name,
Your mother's name,
Your father's name,
Your brother's name. —

By Sala Weltman, age 12, the first prize poem in the annual high school poetry contest in New York City, copied from the Westchester Medical Bulletin.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT STATE MEDICAL SOCIETY (1940-1941) 4

OFFICERS AND COMMITTEE CHAIRMEN OF THE CONNECTICUT HOSPITAL ASSOCIATION (1939-1940) 5

ORIGINAL PAPERS:

Organization of Medical Services for the Care of Civilians Injured in Air Attacks — Ebbe Hoff, M.A., Ph.D. 501

Health for Pupils and Teachers . . . Ira V. Hiscock, Sc.D., New Haven, Conn. 509

Medical Preparedness in Connecticut . . Creighton Barker, M.D., New Haven, Conn. 513

Recent Advances in Chemotherapy . . . Joseph Millett, M.D., Hempstead, New York 515

EDITORIALS:

The Ramparts We Watch 524

Doctor Higgins Half a Century in Practice 525

Doctors of Dental Medicine—A New Product at Harvard 526

Alpha and Omega 527

War Times Are Strange Times 527

Elmcrest Manor Offers New Facilities 527

New Haven Hospital Revolutionalizes Operating Room Policies 528

FROM THE SECRETARY'S OFFICE 529

CONNECTICUT HOSPITAL ASSOCIATION 530

REPRINTED PAPER:

The National Health Program a Front for Socialism 533

THE DOCTOR'S OFFICE 535

GENERAL PRACTITIONER'S FORUM 535

OUR NEIGHBORS 536

NEWS FROM COUNTY ASSOCIATIONS 537

PROCEEDINGS — ANNUAL MEETING HOUSE OF DELEGATES 539

SPECIAL NOTICES 545

OBITUARY:

Henry LeBaron Peters, M.D. . . . . D. C. P. 547

ABSTRACT:

Allantoin, A Possible Leucocytosis Producing Factor — Frederick R. Greenbaum, D.Sc. 546

QUARTO NOTES (Book Reviews) 548

ROSTER OF MEMBERS 551

Enduring Character

Sixty-four years—time to train succeeding crops of young men in Lilly traditions—time to establish a solid foundation on a policy that is strikingly like the Golden Rule.

EXTRALIN

(LIVER-STOMACH CONCENTRATE, LILLY)

'Extralin' provides the antipernicious-anemia principle in a highly concentrated form for oral use. With 'Extralin' the blood count may be maintained at normal levels with the least amount of inconvenience to the patient. Nine to twelve pulvules daily constitute an average maintenance dose.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

The Connecticut State Medical Journal

VOL. IV. SEPTEMBER, 1940 No. 9

Organization of Medical Services for the Care of Civilians Injured in Air Attacks

EBBE HOFF, M.A., Ph.D., Oxford, M.R.C.S., L.R.C.P.

Doctor Hoff has served since the beginning of the present European war in various Casualty Clearing Hospitals and Base Hospitals in London under the Emergency Medical Service. During that time he has had personal experience with problems arising out of the organization and operation of such hospitals. He has also come in contact with alterations in medical education arising out of the present conditions. Doctor Hoff returned from England on June 21, 1940. (*Editor.*)

The effects of war have always provided problems for medical men, and wherever the armies of history have fought there also the soldiers-doctors- men of genius like Ambroise Pare and Harvey Cushing and thousands whose names are forgotten — have carried their profession to the battlefields in an attempt to mitigate the havoc of the conflict. War and disease go hand in hand, the one preparing the the way for the other; but whereas man's ingenuity applied to medical research has shown how to combat many illnesses by preventing their occurrence and spread, in the case of war the preventive approach which has yielded such fruitful results in the struggle against disease seems to be completely beyond the scope of our science. Doctors now as in the past seem to have no choice but to stand ready should need arise and to do their best to repair the damage when it is done.

Modern war has descended upon a large part of the world armed with new and somewhat unexpected terrors. To those who imagined that great cities would be laid in ruins over night, war may not seem to be living up to its reputation; to those who have seen what has happened already and who realize what may yet happen, the war is terrible enough. In its quiet phases, war bides its time, making use of highly organized propaganda, spreading anxiety, tension and uncertainty and finally lulling its victims into a state of apathy and boredom. Then suddenly it strikes with lightning swiftness and paralyzing ferocity. Europe has experienced both of these aspects of modern war: the long periods of waiting characterized by persistent air reconnaissances, systematic assault on trade routes and propaganda from within as well as from without; then the bursts of furious activity — aircraft attacking with high explosive and incendiary bombs, cannon and machine guns, troops dropped from the air, and all this synchronized with highly efficient mechanized operations on land and sea. Nor does the armentarium of war seem to have been yet exhausted. Toxic gases, particularly mustard gas, may still be used and very probably there are surprises in store about which one can only hazard guesses.

Great use has been made in propaganda of the threat of total warfare. The old fronts of previous wars are said no longer to exist. The new theaters of war, we are told, are in the streets of cities and in people's homes. Unfortunately, this propaganda has been shown by recent events to be no idle threat. On some the brunt of the war has fallen more heavily than on others but no one within its sphere of influence is safe. In addition to the risks he runs, the citizen is harrassed in a multitude of ways. Food restrictions, the black-out nights in air-raid shelters, the howl of air-raid sirens, the drone of aircraft overhead, the sound of anti-craft fire and in some places even the sight of extensive wounds have become part of the pattern of everyday life. In every possible way the enemy seeks to destroy public morale in an attempt to force acceptance of capitulation as an alternative to annihilation.

Such conditions create novel problems for the medical and health services of a country, and within a comparatively short time, the medical defense and care of civil population in the event of aerial bombardment or other attack has become an important and highly essential specialty of medicine and surgery. In the past year or two, particularly since the outbreak of the present war in Europe, the literature on this subject has become enormous. One can readily appreciate the difficulties facing those who have had the responsibility of organizing the civil emergency medical services. It has been impossible to predict exactly what functions these services might be called upon to perform. Even the experiences in China, Abyssinia and Spain are of limited value in planning such a medical organization since new situations may be very different. How can one tell when attacks will occur? Will they come tonight, next week, next month or never? How long will they last and at what points will they be directed? How many casualties may be expected and where will they be concentrated? What other methods of assault may be used to reinforce air attack? These are difficult questions to answer. Those who organize the emergency medical services must therefore envisage and provide for a wide variety of eventualities with the hope that many of the provisions will never have to be put into force. While hoping for the best, they must quietly prepare for the worst.

Civil and military medical services face common problems in modern warfare and ought to be coordinated as far as possible. The civil services, however, have to cope with particular difficulties which do not arise or have already been satisfactorily dealt with in the fighting forces. For example, civil populations are not as well disciplined as armies and the hampering effect of panic must be given greater consideration. Also, women and children are among those requiring care in attack on towns and open country, a terribly distressing complication not encountered in the work of the army medical corps. Both the civilian medical defense services and the military medical corps must be so organized that they will provide adequately for the medical and surgical needs of the ordinary sick during periods of quiet and at the same time be immediately adaptable to active war conditions.

The only real test of the war-time medical services comes when bombs begin to fall and convoys of wounded start to pour into the hospitals. Obviously, no one can pretend to speak with absolute authority on organization of emergency medical services, a matter so fraught with uncertainty and so subject to the vagaries of a rapidly changing situation. With these reservations I should like in this article to draw attention to some of the considerations which I believe from personal experience in the Emergency Medical Services in London must be kept in mind in providing for the care of civil population in war-time.

First-aid parties, rescue and demolition squads, ambulances.

Under the Air Raid Precautions Act, 1937 and the Air Raid Precautions (General Schemes) Regulations, 1938, arrangements in England for collection of casualties, their transmission to First-Aid Posts or receiving hospitals and their treatment at the First-Aid Posts are placed under the jurisdiction of county and borough councils and other local authorities. All hospital treatment as well as interhospital transport are supervised directly by the Ministry of Health.

Each First-Aid Party consists of four men trained in first-aid and stretcher bearing. These groups are stationed at convenient depots throughout the local district and can be sent at once to any area where casualties have occurred. These groups work in cooperation with Rescue and Demolition Squads and with Ambulances which are provided by requisitioning commercial vehicles. These can be quickly converted so as to carry two to four stretcher cases and are also held in reserve to be concentrated on bombed areas when need arises. Members of First-Aid Parties may in some circumstances be the first to see patients and may therefore have to accept the heavy responsibility of deciding what initial disposal shall be made of individual cases. Since it is so important that these patients be sent with as few delays as possible to an adequate treatment center, the initial routing of casualties is a vital matter. Without doubt a doctor should be present at the site of a raid and be the first to see the patients. In times of heavy bombardment this may not be possible; however, in districts where Mobile Units can be called upon, a medical officer and nursing staff become available with facilities for requesting further medical assistance should this be thought necessary.

The Fixed First-Aid Posts.[1]

These Posts were designed to act as buffers to the Casualty Hospitals and so prevent them from becoming congested and overcrowded by the less seriously wounded and by persons suffering from acute fear. It is intended that they should treat and send to their homes patients with minor injuries and that they should provide cleansing facilities for unwounded or wounded who have been contaminated by mustard gas. Such seriously wounded patients as may be brought into the First-Aid Posts are to be given only the necessary immediate treatment and then sent on to an appropriate treatment center. The First-Aid Posts are supervised by the local medical officer of health and the large posts consist of a doctor with a staff of 60 (10 men and 50 women). In small posts a medical officer has charge of a personnel of seven men and thirty women. The staff works in shifts and in active areas can be increased if necessary. There should be trained nurses at each Post. The First-Aid Posts are located in hospitals or in buildings near hospitals scattered throughout the district.

There has been considerable controversy as to the value of such fixed first-aid stations. By the very fact that they are fixed in position their use is limited to occasions when air attacks occur in their vicinity. To be effective, posts must therefore be maintained all over a vulnerable district although some may conceivably never function once during the entire war. Others, situated near important targets, may be constantly over-worked. The fixed posts have this important advantage, however, that the civilians know where they are located and walking cases will assemble there for treatment and so hospital services may be spared for the more seriously wounded. Also, by their very presence in well-known locations, the fixed posts may do much to inspire public confidence.

Another criticism of fixed first-aid stations is that they may tend to delay direct transport of serious cases to hospitals where really adequate treatment is available. If first-aid parties are allowed to send such cases to the first-aid stations and if in these stations valuable time is wasted administering elaborate "first-aid" to seriously wounded patients, then, certainly, they can do more harm than good. This seems to have been the experience with first-aid posts as organized in Barcelona during the early part of the Spanish War. Trueta, formerly Chief of the Surgical Clinic of the General Hospital of Satalunya, center for civil defense in Barcelona, believes that first-aid stations should always be organized within the hospitals themselves.[2] He considers that only in a hospital can a patient be properly examined and the true extent of his injuries ascertained. Experience in Barcelona has shown how easily certain types of wounds produced by splinters from light-weight bombs could be overlooked. These bombs were covered with a casing of some light material such as aluminum which burst with great violence, dispersing thousands of small fragments not much larger than a finger nail. These splinters, often heated to incandescence, were projected at a high velocity with a rotatory movement and they inflicted damage to internal tissues all out of proportion to their small, inconspicuous and often insignificant wounds of entry. Since patients wounded by these fragments were frequently in a state of apathy or indifference as a result of the explosion itself and did not complain of pain, the gravity of their injuries might escape recognition unless they were undressed and carefully examined. Such patients in a busy first-aid station might not be seen by a medical man at all and could possibly be sent home with a dressing, only to develop gas gangrene later on. The danger of such unfortunate mistakes may have been somwehat overstressed but it is certainly true that if first-aid stations are to play an effective role in the treatment of civil casualties they must not only protect the hospitals from an influx of minor cases but they have also to be so staffed and operated that severe cases are diagnosed and efficiently routed to proper treatment centers. Immediate intervention of a surgeon in an adequately equipped surgical hospital is the only useful form of first-aid for the seriously wounded after the arrest of active hemorrhage and perhaps administration of morphine.

The Mobile Units

In addition to fixed First-Aid Posts, many districts have been provided with Mobile First-Aid Units[3], [4]. The Mobile Unit consists of a motor van with removable cupboards in which are stored drugs, instruments, dressings, splinting, hot water bottles, apparatus for sterilizing and other necessary equipment for a temporary first-aid post. The Units have their base at a hospital or similar center and the personnel is recruited in part at least from the full-time medical and nursing staff of the hospital. There is a medical officer in charge of the Unit, with one trained nurse and a staff of 18, working in shifts. In some districts the staff has with advantage been reduced in number to a full-time group composed of a doctor, one staff nurse, five junior nurses and two trained orderlies. The Mobile Units are directed from a central control body and can be dispatched in any required number to the site of bomb explosions. Treatment is not carried out in the van but a temporary post is set up in some nearby building considered suitable for the purpose, and the Unit works in cooperation with the local Air-Raid Warden, the police, Rescue and Demolition Squads, stretcher parties and ambulances. If necessary, additional medicinal help can be summoned, Minor injuries are treated and sent home. Some emergency operations may have to be performed, such as amputation of limbs crushed and trapped by fallen masonry and arrest of acute hemorrhage. In general, every effort is made to sort out patients and dispatch them as quickly as possible to the Casualty Clearing Hospitals, sending such cases as those with penetrating head injuries directly to the appropriate Base Hospitals.

During the latter part of the Spanish War, Mobile Units were used in Barcelona, and under the conditions prevailing there, seem to have functioned well. Small towns and the countryside around Barcelona were sometimes the objects of low-flying attacks and some machine-gunning but within the city itself, because of the anti-aircraft defenses, attacking planes were forced to fly at a height of about 3000 feet. Three types of bomb were dropped on the city; heavy bombs weighing over 600 pounds, small incendiary bombs weighing two or three pounds and light-weight high explosive bombs. The heavy bombs were used with the apparent object of destroying buildings and in this they were extremely successful. Stone and concrete structures were quickly demolished and where the bombs fell in the streets, they dug craters some ten feet deep bursting into large rough fragments flying upwards and outwards. Within the zone of greatest violence of the explosion, bodies were found torn to pieces or badly mutilated while further away there were dead showing no external injuries but often extensive rupture of hollow viscera. Death in these cases seems to have been caused by sudden compression and decompression of the atmosphere, *i.e.* the blast from the explosion. Many persons also were killed by falling bricks and struck by falling masonry; others were buried under debris or asphyxiated by carbon monoxide in enclosed spaces. Wounds caused by these bombs were grave; cases with severe chest and abdominal injuries did not usually survive. Limbs were blown off and head injuries were common. Wounds were characterized by great destruction of tissue and were associated with severe shock. Very often flying bomb fragments produced serious casualties hundreds of feet from the explosion center.

Incendiary bombs were used in Spain and more recently in Poland, Finland and the Low Countries. Wherever they have been effective in starting fires they have caused severe burns and other casualties due to explosion of the gas mains in burning buildings.

Reference has already been made to the light-weight type of bombs. Trueta points out that the fragments resulting from their explosion have a low horizontal spread so that wounds from this cause are most often to be found in the lower abdomen and the legs. Wilson reports that wounds due to similar bombs were located mainly above the knee-joint.[5] These injuries are also attended by shock and hemorrhage. The effect upon persons in the vicinity of the explosion of these smaller bombs is variable. Members of the B.E.F. returning from the sand dunes at Dunkirk have told me that bombs exploding in the sand produced little damage except in the immediate area and that the men who lay flat with their bodies partially buried were relatively safe.

In any bombardment of a defended metropolis a certain number of casualties will result from splinters and shrapnel from exploded anti-aircraft shells. It is not possible to say how numerous such injuries will be. Steel helmets offer some protection and the large numbers of surface shelters which have been designed are presumably intended to shield pedestrians from these missiles. Such shelters are of no value against the effects of a direct hit, of course, or even against the blast from an explosion nearby.

There has been considerable difference of opinion over the question of suitable air-raid refuges in cities and towns liable to air attacks. Haldane and others, on the basis of their observations in Spain, have advised the construction on a large scale of deep subterranean refuges for the accommodation of civilians. How deep these shelters should be is still a matter of some dispute but it is generally believed that a shelter 40 feet below the surface of the ground affords absolute protection against any known explosive missile. It has been suggested that these deep shelters be constructed beneath public parks and that they be used for car parking in peace-time. Shelters much nearer the surface are not without value however. I have been told by eye-witnesses at Dunkirk that although in many sections of the town rows of houses were completely demolished by aerial bombardment, the cellars were still intact and in these cellars women and children remained and survived throughout the entire operations.

From this discussion one may form some idea of the injuries that the Mobile Units and first-aid parties are likely to meet in air-raids. No mention has been made of psychological casualties or of the effects of gas attacks. For adequate treatment of the former specialists' care may be necessary. Measures against gas include provision of respirators for the whole population (a special type for infants), and arrangements for cleansing persons contaminated with mustard gas and decontamination of areas where gas is present.

The nature of air-raid casualties demands early treatment. In an efficiently operating first-aid system every effort must be made to get patients to the hospitals where they are to be treated as soon as possible. It has become obvious, for example, that patients suffering from penetrating skull wounds should be sent directly to neurosurgical base hospitals. To waste time giving "first-aid" to these cases in first-aid posts or to try to deal with them in a crowded advanced casualty clearing hospital is only to place their lives in even greater jeopardy. Under the care of a neurosurgeon in a hospital staffed and equipped for intracranial surgery, where early operation can be performed but where time can be taken for preoperative X-rays and other necessary procedures, the patient has the best chance for recovery with least residual disability[6]. In the base hospital also, he may remain undisturbed after operation under specialized care.

Principles which should guide us in dealing with head injuries may also be applied to cases with extensive face wounds which are best treated in special hospitals away from target areas. Cases of open fractures, in which hemorrhage and shock are unimportant, and the injured part can be satisfactorily immobilized and where the hospital is not more than two hours away, may also be considered suitable for direct transport to an Orthopedic Base Hospital for treatment. Under no circumstances may these cases be allowed to wait about in a first-aid post, for there is a vast difference in the prognosis of those treated by an orthopedic surgeon within a few hours by radical incision of the wound and immobilization, and those who have been neglected or wrongly treated for 24 hours.

The Casualty Clearing Stations[7]

The Casualty Clearing Stations are the advanced hospitals of the Emergency Medical Services in London. The London area has been divided into ten sectors each with its apex near the center of the metropolis and widening out to a base 30 or 40 miles away. Each of these sectors is associated with one of the large teaching hospitals, and the sector officers are chosen from its staff. The teaching hospitals also provide any additional personnel required by the Casualty Clearing Stations, which are scattered throughout the central parts of the sectors, and the Base Hospitals located in the periphery. For example, one metropolitan teaching hospital has jurisdiction over two sectors in which there are 60 subsidiary hospitals. Located in what may be expected to be target areas, the Casualty Clearing Stations are intended primarily for the reception, examination and classification of the wounded, routing of special cases to Base Hospitals, immediate treatment of shock and hemorrhage and care of those needing urgent surgical operations. The work of the Casualty Clearing Stations necessarily includes treatment of minor injuries and some Stations have provisions for cleansing gas contaminated patients. It is important that these hospitals be kept free from congestion and that there be an uninterrupted circulation of patients. Ideally this type of hospital ought to operate on the "one-way traffic" principle. This is illustrated in the accompanying diagram showing the floor plan of a hypothetical casualty clearing hospital.

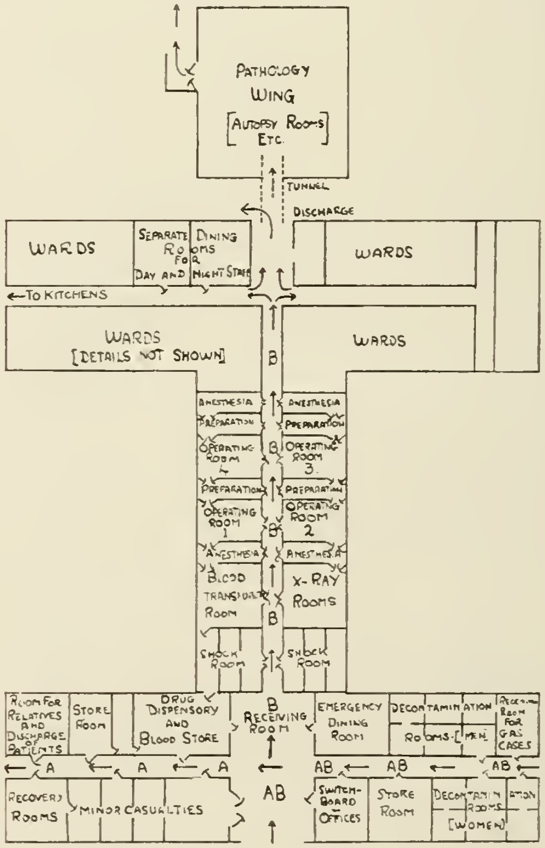
On the Receiving Room Officer and his staff falls the responsibility of reception, examination and routing of patients. The injured arrive in the Receiving Room on foot from the local neighborhood, or are brought in by ambulance, directly or after having been decontaminated. They must be examined as thoroughly as circumstances allow and according to the results of examination may be classified into some such groups as the following:

1. In the first category are those patients who have minor injuries or those contaminated with gas but otherwise uninjured and who will be able to go home after immediate treatment. In the illustration these patients are indicated by the letter A and they follow the direction of arrows, AA.

2. A second important group comprises those to be sent directly to Base Hospitals without operation. These include patients with head injuries, face wounds and certain types of fractures and have been referred to already.

3. In a third category might be grouped all patients requiring immediate treatment for shock and hemorrhage. A large number may require blood transfusion and other treatment before they can possibly survive a surgical operation. After operation in the Casualty Clearing Station many patients can be evacuated in a few days or more, depending upon their clinical condition, to Base Hospitals and so beds kept clear for incoming cases. Patients suitable or early evacuation after operation include those who have had amputations, operations for the arrest of hemorrhage and cases with open fractures and joint wounds[8]. Other cases, such as those with open chest wounds, may have to be kept in the Clearing Station for some time. In some cases, operation may not be indicated but patients will have to remain in hospital.

4. Under certain circumstances, there may be a category of gravely wounded patients



A floor-plan illustrating the arrangement of the services of a hypothetical small casualty clearing hospital. Patients with minor injuries, indicated by the letter, A, are given necessary treatment and sent home. This stream of patients flows in the direction of arrows, AA. The more seriously wounded, indicated by the letter, B, who require in-patient care are routed in the direction of arrows, BB. Patients may arrive contaminated with mustard gas and therefore require preliminary cleansing. In such a hospital, congestion must be avoided and free circulation of patients maintained.

suffering from extensive wounds such as evisceration with multiple perforations. These cases can be given surgical treatment only if the surgical services are not over-taxed In time of stress, the operating facilities must be reserved for those who have a better chance of survival.

This classification of patients is adapted from Trueta's experiences in Barcelona[2]. Under conditions elsewhere, the type of injuries will probably vary somewhat. In disposing of patients, each individual case will have to be judged on its own merits, taking into consideration the number of wounded requiring treatment, the circumstances in which the work of the hospital must be carried on, the state of affairs in the Base Hospitals and the efficiency of transport. Unfortunately for more severe cases, they may be expected to arrive at the Casualty Clearing Station rather later after an air-raid to find the staff fully occupied with the less seriously wounded who were able to get to the hospital earlier.

Patients in categories (2), (3) and (4) are designated in the illustration by the letter B, and are kept circulating in the direction of arrows, BB.

In the hypothetical casualty clearing hospital illustrated in the diagram all of its work is conducted on the ground floor, the upper floors having been closed. The operating rooms have been located in what is presumed to be the best protected part of the building, being shielded from blast by two wings. Sandbags have been used to reinforce the outer walls of the operating rooms, and all hospital entrances are faced with sandbag walls in an attempt to minimize the effect of blast, a precaution which may be of some value. Within the hospital, the ceilings of strategic centers such as the Receiving Room, shock rooms, operating rooms, and wards are supported by steel girders. The hospital has its own emergency lighting system and water storage tanks, and during local attacks danger of explosion is reduced by isolating the building from the city gas supply. The whole hospital can be "blacked-out" at night and there are special provisions for ventilation during "black-out" hours. A kitchen wing and residents' quarters are not shown.

The Base Hospitals, which are situated in the periphery of the sectors in places considered to be less vulnerable, are specialized treatment centers. Medical and surgical chiefs of the teaching hospitals serve on their staffs, and in many instances the special departments of the teaching hospitals, *i.e.* Neurosurgery, Orthopedic Surgery, Thoracic Surgery and so on were entirely transported to outlying Base Hospitals. London County Council Hospitals, Public Assistance Institutions (poor law hospitals) mental hospitals and other similar institutions were selected for conversion into Base Hospitals. To some extent the Base Hospitals carried on with their peace-time functions: the care of the aged, the sick poor and the mentally unsound.

At the beginning of the war, patients in the large central hospitals, particularly the teaching hospitals, were evacuated to outlying institutions. For example, one teaching hospital with a normal total of 900 beds was reduced to 180 for the ordinary sick and 200 beds kept open for casualties. Out-patient departments were closed and these hospitals became, in effect, large Casualty Clearing Stations. As a result of these measures, there were, on September 13, 1939, 200,000 beds available for immediate use completely staffed and supported by operating services. When expected attacks did not come it became apparent that any plan for medical care in air-raids must be so organized that it can handle the ordinary civil practice during quiet periods and at the same time be readily convertible to a war footing in emergency. On this principle, the services of the central hospitals were gradually resumed on a modified scale with provisions for evacuation in case air-raids made this necessary. This large-scale experiment with decentralization of the hospital services of a great metropolis has taught a number of valuable lessons and there are those who believe that in the future, hospitals for in-patient treatment and convalescence should be located in the country around large cities, the central hospitals being used chiefly for emergency and out-patient treatment and as diagnostic centers.

Medical Education in War-time

Training of doctors is one of those essential activities which must continue in spite of war. In England, virtually all medical students were placed in the category of reserved occupations.

The preclinical departments of many London medical schools were moved to Oxford, Cambridge and other smaller towns outside London. Clinical students were all distributed at the beginning of the war to act as Dressers in Casualty Clearing Stations and Base Hospitals of their sector, their maintenance provided by the Ministry of Health. This opened up a tremendous source of clinical material never before available to medical students, but the problem of teaching under the new conditions in an atmosphere of tension was a difficult one. As the scheme began to operate more smoothly, certain larger hospitals in the sector became organized as teaching centers. As far as possible, students completed their early clinical appointments in their own hospital. Special provisions were made for obstetrical and pediatric appointments in hospitals set aside for these services. Third-year clinical students were considered eligible for appointments in hospitals with fewer teaching facilities but with greater opportunities for personal responsibility and experience. As the large teaching hospitals were gradually re-opened, teaching was also resumed.

For the past two years, special instruction in war casualties has been a part of the curriculum of the metropolitan medical schools. It is also felt in certain quarters that during the present emergency, preclinical students should offer their services to local defense volunteer units and many students are now giving their spare time to special military training.

The Emergency Medical Services in Action

Obviously, the whole story of the medical aspect of the evacuation of the B.E.F. from Dunkirk cannot yet be told. This remarkable military operation, involving also the transport, reception and treatment of convoys of wounded, provided a test of the emergency medical organization which has recently been briefly reviewed in the British Medical Journal[9]. These experiences have shown the importance of direct rapid transport and the wisdom of spreading cases over a large number of different hospitals. All who took part in the work were impressed with the value of the close liaisons which have been established between the central control bodies of the sectors and the individual hospitals. The close personal contacts which have been formed throughout the winter and spring have proved immensely useful in the emergency.

The arrivals of convoys from France have offered opportunities of observing and testing the value of new methods of treating war wounds[10], and interest centers particularly around the use of sulphapyridine, sulphathiozole and other sulphonamide compounds in combating wound infections. Isolated reports of good results of chemotherapy in cases of gas gangrene are now appearing in the literature. There is still uncertainty as to how much credit is to be given to serum treatment and careful immobilization which some of these cases received in addition to drug therapy. The question has arisen whether chemoprophylaxis should be given to all cases of war wounds, and so far there seems insufficient data upon which to base an answer. It has been suggested from the results of peacetime experiences that systemic administration of sulphonamide drugs should be withheld until signs of infection actually appear. Advocates of this procedure point out that prophylactic administration of the drugs may selectively breed out resistant species of organisms in the wound flora which may set up an infection that would not yield to subsequent treatment. It is possible also that prophylaxis with sulphonamide compounds may so depress the leucocyte count as to impair the body's defenses against bacterial invasion. By waiting until the leucocyte count begins to rise, the maximum efficiency of these drugs is said to be attained.

A complete account of the results of modern treatment of war wounds based on recent experience should answer many of these questions and will be eagerly awaited.

REFERENCES

1. Seeley, C. Organization of the Emergency Medical Services II. First-Aid Posts. *Brit. Med. J.*, 1939, **2**; 697-699.

2. Trueta, J. The organization of hospital services for casualties due to the bombing of cities, based on experience gained in Barcelona — with special reference to the classification of casualties. *Proc. R. Soc. Med.*, 1939, **33**; 13-23.

3. Anon. An exercise in A.R.P. *Lancet*, 1940, **238**: 1133-1135.

4. Anon. Mobile units again. *Lancet*, 1940, **239**: 79.

(*Concluded on Page 532*)

Health for Pupils and Teachers

IRA V. HISCOCK, Sc. D.,
New Haven, Conn.†

The health of pupils and teachers in both public and private schools has become recognized as an important part of educational and health programs. The principle of providing educational opportunity for every child was recognized in state constitutions when states were admitted to the Union. When school attendance is made compulsory, the state must assume considerable responsibility for the health supervision of the child. Furthermore, children of school age frequently have handicaps which in a large measure are remediable. Increasing attention is also being given to the health and training of teachers and of other staff members so that they may be well equipped to play a constructive part in the school health program.

To quote from the Appraisal Form for Local Health Work of the American Public Health Association:

"From the standpoint of economy, education and community hygiene, it is believed that every effect should be made to create health conditions for school children which will enable them and society to profit most. It is the purpose of the school health program to provide a hygienic environment in the schools; to prevent the spread of communicable diseases, to discover physical conditions and indices of behavior which are detrimental to the child's well-being and to guide parents in seeking proper professional care, to develop an understanding and practice of the principles of healthful living. The ultimate aim should obviously be to make each succeeding generation better physically and by better understanding of the importance of public and personal health, able to use more fully and effectively the health facilities available."

The Advisory Health Committee of the Connecticut Department of Education has pointed out in its reports, one of which was published earlier in the Connecticut State Medical Journal,* that there are many groups interested in child health, including the parents, physicians, dentists, nurses, departments of health and of education, voluntary health agencies, community social agencies, civic clubs and parent-teacher groups. Careful planning of community and state programs is essential for efficiency and to insure that the various activities are wisely conceived and properly integrated. To facilitate cooperative study of needs, planning of programs, and administration of services, every state and community needs a coordinating committee of the health department and the department of education to clear matters of mutual interest.

Health instruction is definitely a responsibility of departments of education while the control of communicable diseases is definitely a responsibility of departments of health. Some parts of each program, however, may be carried by either and each department may aid the other in many ways. School physicians, dentists and nurses are employed by departments of education in one community and by departments of health in another. Arguments have been presented claiming superiority for each plan. But in practice, the degree to which the features of the school health program are interwoven with other community health activities and the training, personality and ability of personnel are found to be of chief importance regardless of the employing agency. Our objective is the health of the child. "The child receives or should receive service from many individuals, groups, and agencies in addition to his own family. Each has its special task; none can be performed successfully without considering the others. However, the best intentions of one group have often been nullified by ignorance of the work of another, or by the interference or inefficiency of others. Too often people have failed to recognize the simple truth that the child cannot be broken up into parts — one for the parent, another for the teacher, one for the public official, another for the playground, and still another for the church. The child is an indivisiable whole as he grows from infancy to manhood and must be planned for and served as such."*

---

†Professor of Public Health, Yale University School of Medicine.

*See also Report on School Health Policies, J. Am. Med. Assoc., **114**, 1672 and 1930, Apr. 27 and May 11, 1940

About one third of our population is made up of children and young people under 18 years of age. But families are smaller than they used to be; the average, once nearly six persons per family, now is barely four. The White House Conference on Children in a Democracy focussed much attention on inequalities discovered throughout the country in the available opportunities for children and youth in rural areas, in low-income groups, among the unemployed, among migrant workers, and in various minority groups. These groups also usually have larger families than are found among the so-called privileged groups. Such factors coupled with the changing economic structure of modern civilization and of national and world markets, call for measures of a kind different from those that were formerly thought to be suitable.

For convenience, the state advisory committee earlier mentioned has considered the principal elements of a school health program under eight headings:

1. *Healthful Environment.* Attention must be given to the arrangement of the school program and to the social and emotional tone of the classroom as well as to school sanitation and safety. School buildings should be properly constructed and regularly inspected. They should be provided with a safe and protected water supply, and with approved drinking fountains or individual drinking cups. They should have adequate lavatory facilities (including individual or paper towels and soap), and adequate sanitary toilets. Proper areas for recreation with trained supervisors are likewise needed.

The mental health of pupils requires that teaching methods shall give ample opportunity for experiencing success, that disciplinary measures consider pupil personality of greater importance than the rigid application of arbitrary rules and that types of examinations and methods of promotion do not result in discouraging or degrading experiences but stimulate each pupil to do the best he can. Perhaps the most important factor is the personality of the teacher.

2. *Care of Accidents and Sudden Sickness.* A planned written program is needed to meet these problems which may arise at school, for: (1) giving immediate care, (2) notifying parents, (3) getting pupils home, and (4) guiding parents, where necessary, to sources of further treatment. The Division of Health and Physical Education of the Hartford Department of Education has developed practical plans for the care of such emergencies.

3. *Prevention and Control of Communicable Diseases.* The department of health is responsible for the formulation and enforcement of regulations regarding reporting of cases, quarantine, and isolation, and for epidemiological and educational services as indicated. The teacher and other school personnel are in strategic positions to help prevent the spread of communicable diseases. Schools should also be responsible for the following procedures:

a. Notify the department of health of suspected cases of reportable communicable disease;

b. isolate and then send home as soon as possible pupils who seem sick (accompanied by an older person when necessary);

c. encourage parents to keep sick children at home and away from other children(including children with "colds");

d. stimulate parents' interest in smallpox vaccination and diphtheria immunization (especially of preschool children).

It should be emphasized that attendance awards to pupils make parents anxious to have pupils always in school, while the allotment of funds on the basis of average daily attendance makes teachers anxious to force attendance under all conditions. Both practices are based on the false premise that children are always in condition to attend school. Commendation should be given to those pupils and teachers who protect the health of their associates by remaining at home when not well.

---

*Children in a Democracy. General report adopted by the White House Conference on Children in a Democracy, January 19, 1940, Washington, D.C.

In connection with these first three activities, it should be borne in mind that the health of children is not safeguarded when we exclude pupils who are ill but allow an ill teacher, custodian, or secretary to remain in school. Schools have responsibilities for the health of the staff and must see that teaching and working places are sanitary and safe, that provision is made for sick leave, that peace of mind is encouraged by provisions for tenure and retirement, that suitable rest rooms are provided and that teaching and working loads are not unreasonable. Many communities require a health examination of the members of the staff, including such tests as the tuberculin test and x-ray, previous to their employment and periodically thereafter.

4. *Periodic Health Examinations*, and 5. *Special Attention to Those in Need of Medical and ental Care.* There is a tendency to regard the school physician as a school medical adviser and the dentist as a dental adviser. Health guidance for the pupil, his teacher and parents is the objective rather than the detection of symptoms and defects per se. It is hoped that eventually a much larger proportion of our school pupils than at present will receive their health examinations from their family physicians and dentists, the school medical advisers examining (with parents present) those not so examined, besides children referred by teachers, principals and nurses for special reasons. But the schools need to have records of results of all physical examinations of pupils. Medical and dental services should be thoroughly coordinated with existing community facilities and such services should be conducted in a manner that will encourage the cooperation of all recognized medical and dental facilities in the community. Professional services in schools should not, however, conflict nor compete with the private physicians and dentists or other facilities either through treatment, through diagnosis or through giving examinations or advice that may be in conflict with or a substitute for other medical and dental services and facilities.

Experience has shown that annual examinations tend often to become superficial and thus may give both parent and child a false notion as to the content of a good examination, and to relieve parents and children of a sense of responsibility for establishing regular medical supervision outside the health program. Besides the two or three thorough health examinations given to pupils in the elementary grades with parents present, there should be at least one examination provided for each high school pupil. Furthermore, examination records should contain more than diagnostic findings; they should carry also interpretive comment, and recommendations to guide nurses and teachers in giving discriminating attention to individual children. There is urgent need to develop more effective programs for dental health; probably the best such program in the United States is in Honolulu.

The functions of the nurse in the school health program include: assisting the physician in the medical examination of children; inspecting children for signs of communicable diseases as necessary; working with teachers to secure the best adjustment of the school program to the physical condition of the individual child; assisting the teacher in the development, and in the interpretation of subject matter for health teaching; working with parents to secure interest in the findings of the school medical examination and to aid them in planning for necessary care. The character of the nursing service will have considerable influence upon the success of the school program as the nurse acts as liason officer between the school, the health department, the private physician or dentist, and the parent.

6. *Special Education Programs for Handicapped Pupils.* Such provision is made either by adapting the program of the regular class to individual pupils' needs or by providing special classes or special schools.

7. *Supervision and In-Service Training for Teachers.* Specific responsibility needs to be given some person especially qualified in education and in school health work for coordinating all school health activities and for relating these to the community health program. As indicated in the Appraisal Form for Local Health Work, classroom teachers are in a strategic position to influence the health of school children. "It is now recognized that the health of both children and adults depends upon an appreciation of the essentials of healthful living. Thus the school health program

has swung from a medical examination and follow-up of a few specific defects to the development of an understanding of health matters through sound educational procedures. Of necessity, the classroom teacher assumes some parental functions in her supervision of the health of the school child. First signs of disease or abnormal behavior are frequently noted by the teacher which may have escaped the notice of the parent. In being alert, to these deviations from normal health, the teacher can frequently help promote the health of the school child as well as the entire school group. Knowing the child's health background, his behavior in school, and the results of recent examinations, the teacher may be better able to understand the child's limitations, and assist him in meeting these limitations."

8. *A Planned, Coordinated, Graded Program of Health Instruction.* An effective program should give opportunities for experiences through which pupils will develop skill in healthful living and accumulate scientific knowledge relating to the acquirement and improvement of health, including the causes of certain diseases, the way disease is spread, the known methods for preventing disease from both the individual and community point of view, and the hazards of self-medication and of unscrupulous practitioners.

The medical profession has always played an important role in the development and conduct of school health services. Future responsibilities are likely to increase. The importance of the family physician is being increasingly stressed. The modern school medical adviser will need to be well grounded in the principles of personal and public health and their application to school purposes. He should have a special interest in, and give satisfactory evidence of his adaptability for work among children. He needs a psychological as well as a physiological knowledge of children. While it is desirable for certain communities to have a full-time medical director of the school health program, with medical advisers on a full or a part-time basis, it is not always practical. The type of organization and the plan for employment of personnel should be dependent on the needs of the local service. The cooperation of the departments of education and of health and of the other professional organizations is necessary to insure a sound program properly administered.

⁂

MYSTERY OF THE VACANT CHAIRS

"I cannot understand why so few men attend their county and state medical society meetings. It is not because they are so busy, as the busiest physicians are always found where there is a chance to learn. After years of observation I have reached the conclusion that there are three kinds of physicians who don't attend meetings — 1. the person who has not the ability to plan his work so that he can have an evening for recreation at the meeting; 2. the man who thinks he knows it all, has not read a new book since leaving school, and has no time for reading the Journal or other publications; and 3. the man who is afraid he might lose a patient should he leave his office. These three types form the fault-finding group; they complain, but will not come to the meetings and put their shoulders to the wheel, clarify their visions, help remove the faults they see, and become what is most needed by the society and always welcomed by its officers — workers instead of drones or complainers.

"Yes, the opportunity for the present-day physician to be an up-to-date physician is right at his door, and I am not only sorry for those who are missing these opportunities, but for their patients."
—John A. Hawkins, M.D., Pittsburgh Medical Bulletin.

NEW PRODUCT:

The Professional Equipment Company of New Haven is now demonstrating the new Keleket portable x-ray machine for office and home use. It has a capacity of 15 MA at 80 KV. New features include a twenty-four step auto transformer, and a direct reading kilovolt meter. It is carried in three cases of less than forty pounds each. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

(SEE ALSO PAGE 2.)

Medical Preparedness in Connecticut

CREIGHTON BARKER, M.D.,
New Haven, Conn.

The logic of present rapidly moving events again brings into sharp focus the importance of medicine in every pattern of human affairs. It was only a little while ago, although it seems remote, that medicine was directing its attention to rearrangement of its age old method for providing medical care for our people. This question has by no means been answered but suddenly we find ourselves confronted with new and complex demands arising from an unprecedented preparedness program and the unpleasant anticipation of the necessity for defense of our country. Medicine at once finds itself in the forefront of that effort and the national health takes on new significance as a powerful military weapon. Man power and machines are the things that are counted on, but underlying them both is the physical and mental well being of the citizenry.

As we look back upon the events of the last war many shortcomings and inadequacies of preparation come quickly to mind and it seems certain that this time we ought to profit from previous mistakes. It is slow work at best and from it all blunders cannot be eliminated, but many of them will not be repeated.

The medical military authorities of the country have already sought the cooperation and counsel of the American Medical Association and the Association has sent a resolution to the President of the United States and the National Defense Commission asking the immediate appointment of a medical coordinator of all medical services related to the National Defense Program. The Association has proceeded with the establishment of a National Committee on Medical Preparedness and that Committee spreads fanwise into every state with a state chairman on medical preparedness and subordinate units in each county. This organization has been completed in Connecticut and its functions are being carefully considered and weighed so that the most important things will receive the first attention. All the activities fall with some clarity into three catagories no one of which is separable from the others but must be worked out along independent lines.

The first of these is supplying medical and medical-technical personnel for the armed forces and the physical selection of man power. Until the army and navy are expanded to a size beyond a point that does not appear to be contemplated, supplying physicians should not present a great numerical problem but the qualifications of the medical men entering the services should be viewed with fine discrimination so that the most efficient personnel will be available to meet the highly specialized needs. With the operation of a selective service law, comes the demand for doctors to serve on the selective service boards. It is obvious that the choice of this personnel should be left to the medical profession itself for in no other place can the understanding knowledge of the availability and skill of physicians be found. The Connecticut State Medical Society has already volunteered to meet this responsibility.

Second, the needs of the civilian population must be met and medical care for the public continued without impairment. This will call for a knowledge of which physicians can be spared from their civilian pursuits and may occasionally require the tactful discouragement of patriotic motives on the part of individuals who do not realize that the field of their greater service is at home, communities and hospitals must not be deprived of medical service. The American Medical Association has requested the National Defense Commission and the Congress, in preparing for conscription, to provide for the continuation of medical education and for exemption from conscription of all medical students and internes in accredited and approved hospitals.

A new civilian demand will inevitably present itself in the increased vigilance that must be directed toward the maintenance of health and efficiency among industrial workers. The program of material production may be greatly handicapped by loss of time arising from accidents and occupational hazards. There are many new industrial processes that present chemical and ventilation problems that are as yet only partially understood, and physicians, chemists and physiologists must be relied upon to solve these. An interesting and far reaching training program in this field is in the process of development by Yale University, a program in which The Connecticut State Medical Society and the State Department of Health welcome the opportunity to cooperate. Emotional effects will surely come with industrial speed-up, and personnel experienced in the field of preventive psychiatry will be called upon to meet these problems. The Committee on Medical Preparedness of the American Medical Association has recommended to the National Defense Commission that funds be furnished to the United States Public Health Service to provide the necessary training of physicians, chemists, mechanical engineers and other professional personnel in order to cope with the industrial hygiene problem in the national emergency.

Third, the whole field of activity that is known as public health will expand beyond any previous concept. Connecticut is fortunate in having efficient and well integrated public health authorities and their abilities and resources will be called upon to extend and strengthen their control of water and food supplies, the prevention of epidemics and the supervision of areas in which troop concentrations are located. But these official health agencies will not be adequate without the thoughtful and willing help of private physicians everywhere.

These are the things that will come first and while they are being arranged in an orderly pattern, wise people will look grimly ahead to the possibility of invasion and the resulting chaotic disturbance of the civil organization upon which we rely. Connecticut and adjacent states are in an exposed and vulnerable position and would surely become a target area for an invader. Plans for the evacuation of the civilian population should be contemplated and paper organization made for the care of casualties among civilians. We view with pride and security our well organized and splendidly equipped hospitals which we are confident could carry almost any emergency load if they were emptied of their peace time population, but another picture would present itself if some of those hospitals were no longer operable and their abandonment forced. These are not happy circumstances to contemplate, but if they may come, there is much to be gained from their thoughful anticipation.

There is no time for apathy or stubborn adherence to a wishful remoteness. Physicians, perhaps more than any others, detest war because it is wholly contrary to their creed of charity and tolerance. But we also love liberty and independence and if our democracy is to stand, we, of our own free will, must now do our part with calm deliberation.

——☆☆——

ROUTINE PROCEDURE OF IMMUNIZATION OF CHILDREN

The first immunization procedure for a child should be vaccination against smallpox, which should be performed within the first three months of life, *The Journal of the American Medical Association* for Aug. 10 recommends.

"Next in order," *The Journal* observes, "immunization against whooping cough is advocated by many. Ordinarily this procedure is not advised prior to the second half year of life. As a rule, when the child has reached 9 months of age it should be immunized against diphtheria. At this time the combined method of establishing immunity against both diphtheria and tetanus may be adopted. Between the ages of 1 and 2 years consideration may be given to inoculation of the child with streptococcus toxin for the purpose of establishing immunity against scarlet fever. Some hesitate to resort to the last named procedure because of the possibility of severe reactions. Vaccination against small-pox should be repeated when the child enters school and again before entering college. Schick and Dick tests (for diphtheria and scarlet fever, respectively) should be done when school age is reached in order to determine whether further immunizing substances are required."

Recent Advances in Chemotherapy*

JOSEPH MILLETT, M.D.†
Hempstead, N. Y.

Today we are on the threshold of developments in medicine which may not be paralleled for some time. The recent rapid progress in the field of chemotherapy has furnished the occasion for some of the finest chemical and pharmacological work of the century. There is no knowing where these investigations may lead, either in the direction of improving the present treatment of streptococcal, pneumococcal, or gonococcal infections, or of broadening the scope of treatment to include virus infections as well.

The greatest role that sulfanilamide plays in medicine is the rapidity with which it controls dangerous infections due to the beta hemolytic streptococcus. To Domagk and his coworkers in Germany belongs the credit for initiating the studies with the prontosils. The Trefouels, Nitti, and Bovet in France discovered that the sulfanilamide portion of the complex prontosil compounds, a simple molecule, could do the work of the original drug. Colebrook and his associates in England, and Long and Bliss in America carried on careful clinical and experimental studies which launched the rational clinical use of these drugs. The clinical response to such dangerous acute streptococcus infections as meningitis, septicemia, puerperal fever, erysipelas, cellulitis, acute otitis media, and mastoiditis can be considered dramatic.

The absorption, excretion, pharmacology, toxicity, and mode of action of sulfanilamide have been extensively studied. Ordinary doses are absorbed in about four hours from the alimentary canal, and an effective level in the blood and spinal fluid is quickly obtained[1]. It also penetrates into all organs, secretions, and effusions, as well as into the foetal tissues when administered to pregnant animals[2]. However, it has been shown that there are variations in absorption in different individuals which may at times be considerable[3]. Sulfanilamide is completely excreted in the urine in twenty-four hours in both a free and conjugated (acetylated) form. Alyea[4] has shown quite definitely that kidney damage delays excretion, while Stewart[5] has demonstrated that watery diuresis increases the urinary excretion of the drug.

The mode of action of sulfanilamide has not as yet been explained adequately. At present it is felt that the action of the drug is one of direct interference with bacterial metabolism hindering or preventing growth and thus leading in the end to the death of the organism. Gay and Clark[6] are convinced of the importance of the slowly mobilizable cells of the macrophage series in natural resistance and acquired immunity to streptococcus infections. Using an experimental syndrome, streptococcus empyema in the rabbit, they found that co-operation on the part of the locally derived clasmatocytes is apparently required for complete sterilization of the animal body. This conclusion was reached through direct histological demonstration of a precocious and increasing mobilization of clasmatocytes in the parietal and visceral pleura. In other words, sulfanilamide apparently produces a bacteriostasis sufficiently marked to protect the accumulated leukocytes and to allow for the rallying of the natural defense macrophages.

Application to Infections

The rational use of sulfanilamide definitely demands a bacteriological as well as a clinical diagnosis. It is a specific for certain organisms which produce a pathological process, and not for the process itself. Its use should be limited in general to those diseases in which sound experimental or clinical research has demonstrated the beneficial effects of the drug.

---

*Read by invitation before the Fifteenth Clinical Congress of the Connecticut State Medical Society at New Haven, Sept. 21, 1939

†Jr. Attending Physician—Meadowbrook Hospital, Hempstead, N. Y.

Sulfanilamide has definitely earned a place in the treatment of all acute infections caused by beta hemolytic streptococci and meningococci. One fact should not be lost sight of, namely, the use of sulfanilamide in chronic streptococcic infections. Purdie and Fry[7] reported a case of chronic hemolytic streptococcus infection with draining sinuses from the groin and abdominal wall which repeatedly cultured hemolytic streptococci over a period of three years. After ten days' treatment with sulfanilamide the wounds began to dry up, the discharge became sterile, and the sinuses finally closed after three weeks. Colebrook[8] also described a case with very extensive suppuration involving cellular and bony tissues of the pelvis with many sinuses which had persisted for several years. The patient's recovery under sulfanilamide treatment was dramatic and Colebrook noted that the chronicity of the lesion did not interfere with the curative action of the drug.

Medicine is an experimentally minded profession and the drug has been used for many a variety of infections. Sulfanilamide is effective in B. coli infections of the urine[9], [10] and Proteus vulgaris[11], and fluids should be limited in these cases to assure high concentrations of the drug in the urine. It is ineffective against streptococcus fecalis and Group D. hemolytic streptococci. Sulfanilamide penetrates into the prostatic secretion and is useful when prostatitis exists.

Suppurative pylephlebitis[12], a disease of serious prognostic import due to B. coli, has also responded to sulfanilamide. A few clinical reports on staphylococcus infections are encouraging and suggest the use of sulfanilamide in these infections[13], [14] although Long and Bliss believe it to be of slight value in these cases. Excellent results have been reported in typhoid infections in experimental animals, but as yet only two[15], [16] case reports have appeared in the literature, both reporting the successful treatment of urinary carriers of this disease. Gas gangrene[17] has been mentioned in a few clinical reports, and these justify the use of the drug when indicated. Actinomycoses[18], undulant fever of both melitensis[19] and abortus types[20], malaria[21], [22], chancroid[99], and bubonic plague[23] are reported to have yielded to sulfanilamide therapy.

The use of sulfonamide compounds for the control of virus infections has not proved successful, but there are two types of virus diseases, lymphogranuloma inguinale[24], [25] and trachoma[26], [27], [28] in which these drugs appear to have a curative action.

Sulfapyridine

Among the numerous bacteria on which sulfanilamide is known to act, the pneumococcus has occupied a subsidiary place. On May 28, 1938, Dr. L. E. H. Whitby[29] reported that a newly synthesized sulfonamide compound, 2; (p-aminobenzenesulphonamido) pyridine had a remarkable action on pneumococcal infections in mice. Shortly after this Telling and Oliver[30] reported an interesting observation in three cases of pneumonia. Following the administration of the drug, pneumococci in the sputum lose their capsules, a change which can be demonstrated by appropriate staining methods and through loss of agglutinability by type specific serum. Stripped of their capsule, the virulence of the pneumococci is lost. By passage through mice these cocci recovered their capsules and original type specificity. This work was later confirmed by Lawrence[31] in two cases of Type III pneumonia. These observations duplicated the findings of Whitby in his work on mice.

Since these early reports a number of careful studies on large series of patients have established several facts: There is a sharp drop in temperature within thirty-six hours, a marked reduction in toxemia, and a striking general improvement in the patient's condition. The outstanding feature of all these reports is that sulfapyridine has reduced the mortality from pneumonia due to the pneumococcus. The death rate from pneumonia at the Henry Ford Hospital has been reduced 37 per cent to 8 per cent following the introduction of sulfapyridine therapy[32]. Pepper et al[33] in Philadelphia in a series of 400 typed cases had a mortality of 8 per cent. Allison[34] of the Nassau Hospital, Mineola, New York, reported a pneumonia mortality of 18 per cent from 1935 to 1938 inclusive. In his present series of 100 cases treated with sulfapyridine a mortality of 4 per cent was obtained.

The dosage of sulfapyridine can be considered fairly well established. Following the initial intake of 2 grams by mouth, 1 gram every four hours is administered until a total of 25 grams has been reached. However, clinical judgment should prevail in every individual case.

McLean et al[35] have shown that the pneumococcus can rapidly acquire a tolerance or fastness to sulfapyridine in laboratory animals. They devised a simple test to throw light on the individual sensitivity of the infecting strain. Ross[36] demonstrated this tolerance clinically in a fatal case of pneumococcus meningitis where tests at first revealed an organism sensitive to sulfapyridine. In spite of intensive treatment with blood levels up to 30 milligrams percent, the patient died. The organism isolated at post mortem was shown to be more resistant to sulfapyridine than at the start of treatment. Ross recommends the use of serum wherever possible so that the cocci can be destroyed before they have time to acquire tolerance to the drug. The fact that two cases developed pneumococcus meningitis and[37], [38] died after apparently recovering from pulmonary pneumococcus infection under sulfapyridine treatment, is added evidence that tolerance to the drug established by the organism must be considered in the future.

Pneumococcus meningitis has been successfully treated in a few cases[39], [40], [41]. This disease has also responded to sulfanilamide[42]. MacKeith[43] reports five failures out of seven in pneumococcus meningitis cases treated with sulfapyridine. Long and Bliss saved one case of pneumococcus meningitis out of six. Many more cases will have to be seen before final judgment can be passed in this disease, but in view of the experimental and clinical evidence, sulfapyridine should be the drug of choice where pneumococcus infection of the meninges is present.

While the chemotherapeutic treatment of pneumococcal infections marks a great advance in medicine, it can never by any manner of means replace established serum treatment which has reduced the mortality of certain types of pneumonia here in the United States. Whenever possible they should be used together. Neither should the fact be lost sight of that sputum typings and blood cultures are still necessary for the establishment of the diagnosis, prognosis, and the treatment of pneumococcal infections.

Other infections have been reported to have responded to sulfapyridine. Somers[44] used sulfapyridine in 143 consecutive cases of meningococcic meningitis under field conditions in Sudan. His mortality was ten percent for this epidemic as compared to the mortality of 68 percent from 1934 to 1938. Fenton and Hodgkis[45] reported a case of staphylococcus aureus septicemia secondary to a carbuncle who recovered under sulfapyridine therapy, while O'Brien and McCarthey[46] described a seriously ill patient with a staphylococcus aureus septicemia who showed positive blood cultures for five weeks. The patient recovered after sulfapyridine was instituted. Bowie[47] reported a series of seven cases of gonorrheal ophthalmia neonatorum treated with sulfapyridine. All became bacteriologically negative in thirty-six hours and were discharged after seven days.

I have seen no report on the effect of sulfapyridine on pneumococcus conjunctivitis and the following case from my private practice may prove interesting:

The patient was a five months old infant with a discharging right eye since birth, the other eye being unaffected. A direct smear revealed pneumococci and the patient was put on the usual eye washes and antiseptic. In the meantime culture showed the organism to be Type XIX. The baby was then given ½ tablet (3¼ grs.) of sulfapyridine every four hours. After the second dose the discharge was considerably less and markedly changed in character and disappeared entirely at the end of thirty six hours. The tears fell over the cheek indicating a dacrocystitis. The drug was stopped after fourteen doses (4 grams). After four weeks the discharge recurred and culture revealed a few Type XIX and many untypable pneumococci. Institution of sulfapyridine stopped the discharge and dilatation of the nasolacrymal duct was advised as tears were still dropping over the cheek and the focus of infection was suspected in this area. This was not done at once and the discharge recurred in about three weeks. The patient's duct was then dilated which resulted in complete cessation of the discharge and adequate drainage. There has been no recurrence in six months.

Marshall and Long[48] have employed the

sodium salt of sulfapyridine intravenously in severely ill cases where immediate high blood levels were necessary, in patients who were not responding to oral therapy due to poor gastrointestinal absorption, and in patients who were vomiting. Nausea and vomiting may still occur, due to central effect, but by giving the drug intravenously effective blood levels may be obtained quickly and maintained. Cooper[49] used the sodium salt intramuscularly in a patient with a left upper lobe pneumonia who had been hospitalized two days previously for a massive gastric hemorrhage due to peptic ulcer. The temperature dropped, but because of the painfulness of the injections the drug was discontinued. The temperature rose but dropped again upon resumption of the injections and the patient recovered.

Sulfanilyl-Sulfanilamide

Sulfanilyl-sulfanilamide is a new chemotherapeutic agent which is reported to be especially efficacious in the treatment of gonorrhea. The chemical name of this compound is para-aminobenzene sulfonyl-para-aminobenzene sulfonamide. Experimental evidence [50], [51], [52] revealed that this compound is less toxic and more efficacious than sulfanilamide against streptococcus and meningococcus infections of mice. Alyea, Daniel, and Yates[53] demonstrated that sulfanilyl-sulfanilamide reaches its peak concentration in the blood of the human in seven hours as compared to four hours with sulfanilamide. This is due to the difference in solubility of the two compounds.

O'Crowley, James, and Sutton[54], using 45 grains a day, obtained 94 percent clinical cures in an average of ten days. The same clinic, under the same conditions, obtained 58 percent cures in three weeks using sulfanilamide. Sulfanilyl-sulfanilamide was equally effective in acute and chronic infections. The authors are of the opinion that in their hands the drug was 50 percent less toxic than sulfanilamide and 50 percent more effective. A total of 450 grains per patient was used.

Shelley[55] in his series of 100 cases with an average of 360 grains had only three failures. He noted a small number of his cases of gonorrhea which had failed to respond to sulfanilamide yielded to sulfanilyl-sulfanilamide. Alyea and Daniel[56] carried this study a step further and reported on a number of cases of sulfanilamide-resistant gonorrhea. In a series of 40 cases 60 percent were cured of their gonorrhea. The blood and urine of the patients were not affected. This is an important advance in the treatment of gonorrhea. It is becoming increasingly evident that while sulfanilamide affects gonorrhea as no other agent has done before the present chemotherapeutic era, a certain percentage of patients are resistant to it. James and Sutton[57] used sodium sulfanilyl-sulfanilamide, the soluble salt, and noted that it was effective where both sulfanilamide and sulfanilyl-sulfanilamide failed.

These reports are apparently of a preliminary nature and no doubt more will be heard of this drug in the future.

New Conceptions in the Treatment of Gonorrhea

Whitby[58] has demonstrated both clinically and experimentally that bacteria may evolve into insensitive or resistant strains after treatment by chemotherapeutic means. He feels that what these drugs are going to do, they will do quickly. If the infection is going to be eliminated completely, it must be eliminated rapidly. When repeated courses with chemotherapeutic agents are required, the chance of success is lessened.

The effect of sulfanilamide in gonorrhea in the male can be noted easily. In many cases there has been dramatic and early cure, in others a recrudescence of the infection which is then resistant to drug treatment, or at least to treatment with the same drug. Cohn, Jacoby, et al[59] found that beneficial results with sulfanilamide were apparent after four days of therapy. Where no improvement was manifested increase of dosage or increase of the total time the drug was administered failed to bring about cure of the gonorrhea. Pelouze[60] states that this point varies so seldom that it can be used as a rule. If his patients do not respond in five days to sulfanilamide he places them among the failures and stops the drug. Bowie et al[61] using sulfapyridine in gonorrhea, state that in their experience these drugs perform their work either speedily and efficiently, or slowly and imperfectly.

Whitby has suggested that a change of compound in the sulfanilamide-resistant cases of gonorrhea is indicated. Long and Bliss are in agreement on this point and recommend that when sulfanilamide fails sulfapyridine or sulfanilyl-sulfanilamide be tried instead.

With the advent of these drugs the treatment of gonorrhea apparently has been simplified to such an extent that it is being treated by those unskilled in the urological and chemotherapeutic field. In dealing with a patient who is ambulant and otherwise well, there is a tendency on the part of the physician to extend treatment over long periods of time with increased dosage, especially when the response of the urethral discharge to medication has been poor. This continuous medication only leads to the major, dangerous toxic effects of the chemotherapeutic agent.

A danger of equal importance from the public health point of view is the creation of gonorrheal carriers. A considerable number of patients may be placed in the dangerous state of being symptom free with a latent or residual infection. In many cases the blame falls on the shoulders of the patient who defaults because of the rapid disappearance of the discharge. Until our criteria are so improved that rapid cure can be assured by infallible methods, it is the duty of the physician to impress upon the patient that there are no short cuts to cure and that observation must be carried out over a period of several months before the patient can be safely discharged.

Relationship Between Blood Concentration and Therapeutic Result

A review of several careful studies reveals that there is no definite correlation between clinical results and concentration of the chemotherapeutic agent in the tissues. Vest et al[62] have attacked the problem of the clinical mode of action of sulfanilamide in male gonococcal infections from the point of view of the effect of the drug upon the local infectious process. After a detailed study of 25 hospitalized patients these observers conclude: "There are no differences in the amount of free and combined sulfanilamide in the urine and blood to account for response and non response in such treated cases. There is no difference in the ratio of free to combined sulfanilamide in urine and blood to account for clinical response. Patients have failed to respond with high blood and urine concentrations of sulfanilamide."

Flippen et al[63] in their study of 100 cases of pneumonia, treated with sulfapyridine, noted the concentrations of the drug attained in the blood. Not only did this vary from as little as 1 mgm. to as much as 18 mgm. percent, but there was "singularly little difference in therapeutic effect between groups of patients showing respectively low and high concentrations."

Shelley determined the concentration of sulfanilyl-sulfanilamide in the blood of patients treated for gonorrhea and could not arrive at any definite relationship between blood concentration and therapeutic effectiveness. Alyea and Daniel, using the same drug in a study of sulfanilamide resistant gonorrhea, found that the improved cases had a blood level of sulfanilyl-sulfanilamide of 1.8 mgm. percent while the unimproved cases had a blood level of 3 mgm. percent. They state that in their experience cures are not necessarily dependent on high blood levels.

James and Sutton called attention to the fact that sodium sulfanilyl-sulfanilamide yielded 83 percent clinical cures in eighteen days, while the base yielded 94 percent clinical cures in ten days. This, in spite of the fact that the sodium salt yielded blood and urine concentration three to five times those obtained with sulfanilyl-sulfanilamide.

As Long states: "We must admit that the factors contributing to the failure of sulfanilamide therapy in the adequately treated patient are still unknown and are deserving of intensive investigation."

Toxic Effects

The toxic effects which will be discussed are common to all chemotherapeutic agents. There are certain reactions which are more pronounced with the individual drugs and special attention will be called to them.

Most common among the milder reactions are: Headache, giddiness, depression, disorientation, muscular weakness, loss of energy, nausea, anorexia, diarrhea, constipation, slight cyanosis, chilliness, palpitations, slight dyspnoea, and mild skin rashes. Most of these symptoms tend to pass off in the first few days owing to the development of tolerance to the drug. They also respond quickly to withdrawal of the drug. Some of the symptoms, such as giddiness, disorientation, and depression, while not serious from a medical point of view, are in the ambulant patient a definite danger to the community from the point of view of accidents, as for instance in the case of truck drivers, handlers of complicated machinery in factories, etc. Acidosis is overcome by giving alkalies. Fever which may be severe and is usually abrupt occurs seven to ten days after the beginning of treatment and may be mistaken for a recrudescence of the original infection. Drug fever should be a warning sign and the drug should be discontinued at once as the fever may be ushering in a toxic hepatitis, acute hemolytic anemia, or agranulocytosis.

Dermatitis may occur at any time during sulfanilamide treatment and resembles many of the common types of skin lesions. Tedder[64] classifies the rashes into three groups: 1. Eruptions due to sensitization. These are allergic reactions and can be reproduced by the administration of a single dose of the drug. 2. Eruptions due to the toxic effect of the drug. These disappear if the drug is discontinued, and occasionally smaller doses may be tolerated. 3. Eruptions due to a combined effect of sulfanilamide and light. In the first two groups the rash is more or less generalized, in the third group it occurs on surfaces exposed to light. Light sensitivity may arise in two ways according to Newman and Sharlitt[65]. Either a direct light sensitization caused by the drug as is produced by fluorescent compounds, as eosin, or sensitization indirectly due to the drug by the production of porphyrins. The first hypothesis is made unlikely by the experiments of Eidinow[66] who did not obtain any effects on the skin by exposing to ultra violet light a number of patients who were receiving a sulfonamide compound. The production of porphyrines is known to occur when sulfanilamide is given, and their quantities vary considerably in different cases. Light sensitization due to porphines is well known; therefore, the present evidence seems to point to porphyrinaemias as the cause of light sensitization.

Cyanosis is not an uncommon complication in sulfanilamide therapy and can usually be disregarded. Marshall and Walzl[67] and Chesley[68] have not found any alteration in the oxygen carrying content of the blood in cyanotic patients and have been unable to demonstrate abnormal pigments on spectroscopic examination. They have looked for other causes of pigment formation. Other clinics have found considerable amounts of met-and sulfhemoglobinemia. It is clear from the literature that the incidence of cyanosis and met-and sulfhemoglobinemia varies from clinic to clinic. Traces of methemoglobin in a person with a reasonable hemoglobin level are of no importance. In a person who is already anemic, the inactivation of 30 percent of the total hemoglobin may be serious. Following a suggestion by Wendel[69], Hartman and his co-workers[70] have found methylene blue an effective antidote. Both sets of workers found methemoglobin in a significant quantity in the majority of their patients receiving sulfanilamide. By the administration of methylene blue intravenously in doses of 1 to 1.5 mgm. per kilogram in a 1 percent solution, the methemoglobinemia and cyanosis dramatically disappear in the course of 30 to 45 minutes, whereas otherwise, it takes one to two days to disappear after sulfanilamide is stopped. Methylene blue can be taken by mouth in doses of 1 to 2 grains along with sulfanilamide every four hours. It is not suggested that methylene blue be given routinely, but in seriously ill patients who develop cyanosis and anemia, it will allow sulfanilamide to be continued without risk.

Agranulocytosis can be considered one of the gravest toxic manifestations of sulfanilamide therapy. There is no question that reports of its occurrance are increasing. One frequently hears of an occasional case which has been recognized but not published. There can be little doubt that others have died unrecognized because leukocyte counts were not made. Colebrook[71] analyzed 24 cases which were reported in detail, and noted that in the development of agranulocytosis there was a striking relationship between the amount of drug administered and the duration of treatment. The average dose administered in these cases was 48 grams and the duration of treatment twenty days. In no less than eleven out of nineteen, in which details of treatment are given, the fall in the leukocyte count took place during a third and fourth course of treatment. Long and Bliss in an analysis of their cases believe that the complication is more likely to occur if therapy is continued beyond fourteen days. They believe that stopping the drug, forcing fluids, and a high vitamin diet are the most that can be done with these patients. Transfusions are advised only if an anemia is present. In their experience the use of nucleotide epararions has never been efficacious. Dangerous agranulocytosis is undoubtedly due to idiosyncrasies in most patients, and blood examinations do not always forecast sudden disaster. In several cases agranulocytosis occurred after chemotherapy had been discontinued[72], [73], [74]. Therefore, blood counts should be taken for several days after medication has been stopped.

Fatal and non fatal agranulocytosis and leukopenia[75], [76], [77], [78], [79] have been reported with sulfapyridine, but whether this occurs to a greater extent than with sulfanilamide cannot be determined until many more cases have been reported.

In a large majority of cases treatment with sulfanilamide induces a mild anemia evidenced by a drop in hemoglobin of 10 to 20 percent. This does not contraindicate continued medication. Acute hemolytic anemia is rare. It is amenable to treatment with transfusion, and subjects of acute hemolytic anemia per se are not necessarily made worse with sulfanilamide[80].

Toxic jaundice due to distinct liver destruction[81], [82] followed by death has been reported.

Nausea and vomiting have been particularly trying reactions with sulfapyridine in many instances. This can be obviated to a great extent by ingestion of milk and fruit juices with the crushed tablet. Pepper et al, have found that their best results in combating these symptoms have been by intravenous injections of sodium chloride and glucose, which they believe restore the electrolytic balance of the blood. While a large part of the nausea and vomiting is due to direct gastric irritation, there is no doubt that some of it is of central origin. In a severely ill patient where the drug must be forced in spite of the vomiting, parenteral means, especially by use of the sodium salt, may be the answer.

An unusual complication of treatment with sulfapyridine has been hematuria, and the formation of crystals of sulfapyridine and acetyl sulfapyridine in the urinary tract. Hanson[83] was the first to report this clinically, and this has since been confirmed by other observers[84], [85], [86], [87], [33]. Antopol and Robinson[88] and Gross, Cooper, and Lewis[89] reported similar findings in experimental animals. Needle like crystals of the drug were found in the urine of monkeys, rabbits, and rats. Aggregates of these crystals occurred giving varying degrees of obstruction, the ureters becoming thinned out and hemorrhagic. The uroliths consisted mainly of 64 percent acetyl-sulfapyridine and a small amount of sulfapyridine. They permit the penetration of x-rays except when calcium has been deposited around the concretions. The drug must be stopped and fluids forced when there is abdominal pain, hematuria, or crystals of sulfapyridine found in the urine. This complication necessitates careful observation of the urine in each case treated with sulfapyridine.

Numbness and tingling have been reported, but apparently little attention has been paid to these symptoms. They occur in 1 to 2 percent of all sulfanilamide treated cases. Long [90] has noted it in his cases treated with sulfapyridine.

Neuritis has been seen with both sulfanilamide and sulfanilyl-sulfanilamide. Sulfanilamide produced an optic neuritis[91], a multiple neuritis of the chest wall[92], and a picture of progressive muscular dystrophy involving the extremitis[93]. One report[94] states that several cases of neuritis were seen in a series of obstetrical cases that received sulfanilamide, but the neurological signs were not described. Sulfanilyl-sulfanilamide has also been known to produce peripheral neuritis in a few cases [95], [96], [97]. None have been reported with sulfapyridine.

Under What Conditions Do the Most Serious Adverse Effects of These Drugs Develop?

It can be stated that no toxic reaction can be predicted during the treatment of patients with these chemotherapeutic agents. One who has used sulfanilamide to any extent has been struck by the fact that some patients develop cyanosis after the first few pills, while in others, who have received large doses, the cyanosis is minimal or does not develop at all. Dermatitis may develop in a few hours or several days after treatment has been instituted. Long and Bliss have noted fever as early as two hours and as late as twenty one days after sulfanilamide therapy. In three of Garvin's patients sulfanilamide had been stopped, 4, 7, and 35 days before evidence of liver injury became apparent. Two other patients developed jaundice and hepatitis during the course of treatment. While Wood has determined that acute hemolytic anemia developed in his series between the third and seventh days, Nelson and Scott-Young[98] reported a case in whom acute anemia developed on the twentieth day of treatment. These examples demonstrate that in sulfanilamide therapy, as in other things, the price of safety is eternal vigilance. Unfortunately, in a few of the major untoward reactions, such as toxic hepatitis and agranulocytosis, little can be done in the way of specific therapy. Where long continued and intensive therapy is indicated, careful observation of the patient is necessary to prevent the development of major toxic phenomena.

Conclusions

An attempt has been made to cover the high lights of three chemotherapeutic agents: sulfanilamide, sulfapryidine, and sulfanilyl-sulfanilamide. The rival claims of different sulfonamide compounds have immensely complicated the study of chemotherapy. At present it would seem that sulfanilamide is the drug of choice in all dangerous streptococcal, meningococcal and gonococcal infections; the use of sulfapyridine should be limited to the treatment of pneumococcal infections and the use of sulfanilyl-sulfanilamide to gonococcal infections or sulfanilamide resistant gonorrhea. No experimental method can be the final arbiter between them in other types of infections. The task to be faced in one of clinical assessment on an unprecedented scale.

507 Fulton Ave.

REFERENCES

1. Marshall, E.K., Emerson, K., and Cutting, W.C· — J.A.M.A., 108:953, 1937.
2. Lee, H. M., Anderson, R.C., and Chen, K.K.—Proc. Soc. Exp. Biol. & Med., 38:366, 1938.
3. Stewart, J.D., Rourke, G.M., and Allen, J.G.—J.A.M.A., 110:1885, 1938.
4. Alyea, E.P., Daniel, W.E., and Yates, A.—J. Urol., 41:14, 1939.
5. Stewart, J.D., Rourke, G.M., and Allen, J.G.—J.A.M.A., 110:1885, 1938.
6. Gay, F.P., and Clark, A.R.—J. Exp. Med., 66:535, 1937.
7. Purdie, A.W., Fry, R.M.—Lancet, 2:18, 1937.
8. Colebrook, L.—Lancet, 2:1291, 1937.
9. Butchel, H.A., and Cook, E.N.—Proc. Mayo Clin., 12:444, 1937.
10. Cokkinis, A.J.—B.M.J., P. 1151, 1938.
11. Helmholtz, H.F.—J. Ped., 11:243, 1937.
12. Ottenberg, R. and Berck, M.—J.A.M.A., 111:1374, 1938.
13. Barber, H.W.—Lancet, 2:668, 1938.
14. Colebrook, L. and Purdie, A.W.—Lancet, 2:1237, 1937; Lancet, 2:1291, 1937.
15. Barer, M.—Lancet, 2:964, 1937.
16. Bazin, A.T.—Can. Med. Asso. J., 38:559, 1938.
17. Bohlman, H.R.—J.A.M.A., 109:254, 1937.
18. Walker, O.—Lancet, 1:1219, 1938.
19. Neuman, C.Z.—B.M.J., P.342, 1938.
20. Dalrymple-Charnpneys, W.—B.M.J., P.471, 1938.
Manson-Bahr, P.—Practitioner, 140:740, 1938.
Stern, R.L., and Blake—J.A.M.A., 110:1550, 1938.
21. Pakenham-Walsh, R. and Rennie, A.J.—Lancet, 2:79, 1938.
22. Diaz de Leon, A.—Boll. Off. San. Panamer., 52:1460, 1937.
23. Carman, J.A.—E. Afr. Med. J., 14:362, 1938.
24. Gjurie, N.J.,—Munch. Med. Wschr., 85:335, 1938.
25. Shropshire, G.—Ill. Med. J., 74:97, 1938.
26. Loe, F.J.—J.A.M.A., 111:1371, 1938.
27. Lian, B.—Gen. Tijd. Med. Ind., 78:1025, 1938.
28. Kirk, R.; McKelvie, A.R.; Hussein, H.A.—Lancet, 2:994, 1938.
29. Whitby, L.E. H.—Lancet, 1:1210, 1938.
30. Telling, M. and Oliver, W.A.—Lancet, 1:1391, 1938.
31. Lawrence, L.A.—N.Y. State J. Med., 39:22, 1939.
32. Smith, F.J. and Needles, R.J.—Am. J. Med. Sc., 198:19, 1939.
33. Pepper, D.S.,; Flippin, H.F.; Schwartz, L.; Lockwood, J.S.—Am. J. Med. Sc., 198:22, 1939.
34. Allison, B.R.—N.Y. State J. Med., 39:1558, 1939.
35. MacLean, L.J.; Rogers, K.B.; Fleming, A.—Lancet, 1:562, 1939.
36. Ross, R.W.—Lancet, 1:1267, 1939.
37. Dowd, G. H.—Lancet, 1:1436, 1939.
38. May, K.—Lancet, 1:1101, 1939.
39. Yule, A.P.—B.M.J., P.872, Apr. 29, 1939.
40. Cutts, M.; Gregory, K.K.; West, E.J.—J.A.M.A., 112:1456, 1939.
41. Robertson, K.—Lancet, 2:728, 1938.
42. Allan, W.B.; Mayer, S.Jr.; Williams, R.—Am.J. Med. Sc., 196:99, 1938.
43. MacKeith, R.C.—Lancet, 1:1099, 1939.
44. Somer, R.B.U.—Lancet, 1:921, 1939.
45. Fenton, W.J. and Hodgkis—Lancet, 2:667, 1938.
46. O'Brien, C.; McCarthey, C.J.—Lancet, 2:1232, 1939.
47. Bowie, F. J. T.—Lancet, 2:372, 1939.
48. Marshall, E.K. Jr., Long, P.H.—J.A.M.A., 112:1617, 1939.
49. Cooper, R.—Lancet, 2:72, 1939.
50. Gray, W.H., Buttle, G.A.H., Stephenson, D.—Biochem. J., 31:724, 1937.
51. Barlow, O.W.—Proc. Soc. Exp. Biol. & Med., 37:315, 1937.
52. Rosenthal, S.M., Bauer, H., Branham, S.E.—U.S.P.H. Rep., 52:662, 1937.
53. Alyea, E.P., Daniel, W.E., Yates, A.—J. Urol., 41:14, 1939.

54. O'Crowley, C.R., James, W.L., Sutton, H. Lawrence —J. Urol., 41:51, 1939.
55. Shelley, H.—Bull. School. Med. U. of Md., 23:123, 1939.
56. Alyea, E.P., Daniel, W.E.—South. Med. J., 32:608, 1939.
57. James, W.L., Sutton, H. Lawrence—Am. Jour. Syph. Gon. & Ven. Dis., 23:453, 1939.
58. Whitby, L.E.H.—Lancet, 2:1095, 1938.
59. Cohn, A., Jacoby, A., Kornblith, B.A., Wishengrad, M.—Am. J. Syph. Gon. & Ven. Dis., 23:41, 1939.
60. Pelouze, P.S.—Ibid, 23:48, 1939.
61. Bowie, F.J.T., Anderson, T.E., Dawson, A., Mackay, J.F.—B.M.J., P.711, April 8, 1938.
62. Vest, S., Hill, J.H., Harrill, H.C., Pitts, A.C. — J. Urol., 40:698, 1938.
63. Flippen, H.F., Lockwood, J. S., Pepper, D.S., Schwartz, L.—J.A.M.A., 112:529, 1939.
64. Tedder, J.W.—Arch. Derm. Syph., 39:217, 1939.
65. Newman, B.A., Sharlitt, H.—J.A.M.A., 109:1036, 1937.
66. Eidenow, A.—B.M.J., P.692, 1939.
67. Marshall, E.K., Walzl, E.M.—Bull. J.H.H., 61:140, 1937.
68. Chesley, L.C.—J. Clin. Invest., 17:445, 1938.
69. Wendel, W.B.—Ibid, P.179, March, 1939.
70. Hartman, A.F., Perley, A.M., Barnett, H.T.—Ibid, 17:699, 1938.
71. Colebrook, L.—Lancet, 2:158, 1939.
72. Young, C.J.—B.M.J., P. 105, 1937.
73. Jennings, G.H., Southwell-Sander, G.—Lancet, 2:898, 1937.
74. Taub, J., Lefkowitz, L.—N.Y. State J. Med., 39:1659, 1939.
75. Johnson, F.D.—Lancet, 2:1200, 1938.
76. Coxen, R.V., and Forbes, J.R.—Lancet, 2:1412, 1938.
77. Hobart, D.—Arch. Ped., 56:324, 1939.
78. Rosenthal, N., Vogel, P.—J.A.M.A., 113:584, 1939.
79. Dolgopol, V., Hobart, H.M.—J.A.M.A., 113:1012, 1939.
80. Greenthal, R.M.—J. Ped., 12:517, 1938.
81. Garvin, C.F.—J.A.M.A., 111:2283, 1938.
82. Cline, E.W.—J.A.M.A., 111:2384, 1938.
83. Hanson, P.—Lancet, 1:61, 1939.
84. Adalza, K.V.—B.M.J., P.643, 1939 (March 25).
85. Robertson, K.—Lancet, 2:728, 1938.
86. Southworth, H., Cook, C.—J.A.M.A., 112:1820, 1939.
87. Lawrence, E.A.—Int. Rev. of Recent Advances in Med., 3:48, 1939.
88. Antopol, Wm., Robinson, H.—Proc. Soc. Exp. Biol. & Med., 40:438, 1939.
89. Gross, P., Cooper, F.B., Lewis, M.—Ibid, 40:448, 1939.
90. Long, P.H.—Bull. Gentio, Inf. Dis., 3:1 (Febr.) 1939.
91. Bucy, P.C.—J.A.M.A., 109:1007, 1937.
92. Janet, J.—Bull. Soc. Franc.d' Urol., P.94, March 21, 1938.
93. Ornsteen, A.M., Furst, W.—J.A.M.A.,111:2103, 1938.
94. Williams, B.—Lancet, 1:28, 1938.
95. Rosenthal, S.M., Bauer, H.—U.S.P.H. Rep., 53:40, 1938.
96. Wigton, R.S., Johnson, S.H.—J.A.M.A., 111:1641, 1938.
97. Alyea, E.P., Daniel, W.E.—South. Med. J., 32:608, 1939.
98. Nelson, E.L., Scott-Young, M.—Med. J. Australia, 1:626, 1938.
99. Kornblith, B.A.; Jacoby, A.; Wishengrad, M.—J.A.M.A., 111:523, 1938.

Long, P.H., and Bliss, E.A.—The Clinical and Experimental Use of Sulfanilamide, Sulfapyridine, and Allied Clinical Compounds. The Macmillan Company, New York, 1939.

* * *

Tuberculin Sensitivity has been used in Cleveland as a means of finding early cases of pulmonary disease in the adolescent child without great cost. The small and slowly decreasing number of reactors in the first grade and the high schools, the low morbidity and mortality in both sexes below the 35-year limit, and the drop in unreported cases all support the theory that a consistent use of this method of attack should make tuberculosis a relatively rare disease in about ten years. The fewer cases there are in a community, the more necessary it is to use the tuberculin test among children to locate them. Tuberculin testing eliminated tuberculosis among cattle. It can do the same for man using the reaction as a means of finding tuberculosis in the child's environment rather than in the child himself. Edwards, Jour.—Lancet, 1939, 59.

Because tuberculosis is found 13.5 times as often in families of known cases as in the general population, we should look for tuberculosis in the homes of person who have it. Crusader, May, 1940.

WEATHER MAKER:

For the first time there is now available a perfected and easily installed air conditioner which will really cool the doctor's office at a very nominal cost. Simply plug it in and it will cool, filter, dehumidify, change, and circulate the air. The Professional Equipment Company of New Haven is Connecticut's distributor to doctors.

(SEE ALSO PAGE 2.)

The Connecticut State Medical Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief,*	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Stamford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — William M. Joyce, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

THE RAMPARTS WE WATCH

The business of preparing for the defense of the nation goes steadily on. Medicine has a quietly important part in these preparations and it is reassuring that the American Medical Association and the state medical societies have a leading position in mobilizing the medical forces. Aging veterans of 1917 wistfully hope that some of the outworn conceptions and traditions of the "Old Army" will not confuse things quite so much this time and that first things will come first. Perhaps it will be realized that a competent civilian surgeon can be a valuable man around the operating room in a base hospital, or even in a mobile unit in the zone of the advance without having to spend weeks learning how to steer an ancient calvary mount across the plains of Kansas. Maybe pathologists may go their way about their laboratories unhampered by boots and spurs, and x-ray people left to their tasks with no knowledge of how to keep house in a pup tent. Our own Stanley H. Osborn is a member of the National Committee on Medical Preparedness and George M. Smith has been named the state chairman. Come what may in this adventure, horses in Kansas, boots and spurs in New York and pup tents in Georgia, Connecticut will do her part.

C. B.

* * * *

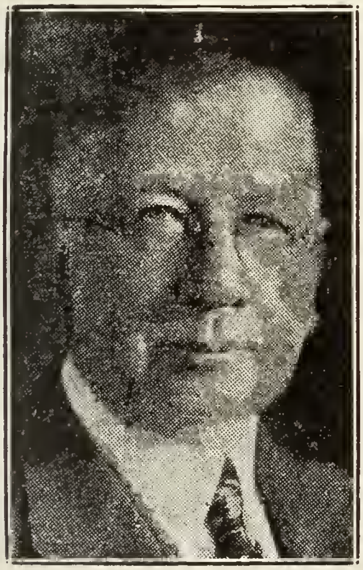
YOUR CLINICAL CONGRESS — THE SIXTEENTH

More than ever the 1940 Clinical Congress is yours, yours to enjoy and yours from which to profit. A careful perusal of the program should leave no doubt in your mind that for your own good you must attend. The three afternoon courses make available opportunities the busy practitioner can obtain as readily nowhere else. The list of guest speakers, representing not only talent from our large Eastern cities but also medical authorities from Detroit and from Montreal, could scarcely be equalled in any postgraduate course. Many subjects of vital importance in medicine today are to be presented.

New features in this 16th Clinical Congress include a shortening of formal papers from forty-five to thirty minutes, the centralization of the entire program within the Sterling Law Buildings, resumption of the noonday lunches with talks by prominent speakers followed by a question and answer period at each, and dry clinics as well as demonstrations of actual diagnostic and therapeutic procedures at the afternoon sessions. The Committee's one aim is to serve you; your aim should be to attend as many of the sessions as it is possible for you to do.

⁂

DOCTOR HIGGINS HALF A CENTURY IN PRACTICE



On May 1, 1940, William L. Higgins completed fifty years in the practice of medicine in Connecticut. Born in 1867 in Chesterfield, Massachusetts, of old New England and Revolutionary stock, he received his medical degree at the University of the City of New York in 1890. He immediately began practice at Willington Hill but in the autumn of the following year moved to South Coventry where he still resides and practices. He is the dean of the medical profession in Tolland county, one of the oldest practitioners in the state and has practiced medicine continuously except for the four years 1933-1937 when he served as a member of congress of the second congressional district. Today at 73 years of age he continues to respond to the night and day calls of his profession as cheerfully and as energetically as ever. He does not object to being called a horse and buggy doctor, although he hasn't driven a horse for 30 years. The hardships of a country doctor, a romantic figure which he symbolizes to the fullest extent, have largely passed away with the improvement of rural roads and the automobile. Despite his tremendous scope of interests and activities as a state legislator, secretary of state and first selectman of his town and many other public efforts, he has enjoyed unusually good health. He has not been confined to bed by illness since 58 years ago, notwithstanding the fact that the demands of his profession have caused him to violate many of the rules of health which he has prescribed and insisted upon for those to whom he has given his services.

While active in his professional work Doctor Higgins has found ample time to engage in many business, civic and political activities. Highest of his offices was that of United States congressman. In the state of Connecticut he has served his town as a member of the house of representatives for seven terms from 1905 to 1927 and was a member of the state senate in the session of 1909. During his first three terms he served as chairman of the committee on humane institutions and the remaining five terms he was chairman of the committee on public health and safety.

He served as secretary of state for two terms beginning in Nov. 1928. Concurrently with these state offices which he used to carry out his long years of work for the improvement of rural roads, he also served as first selectman of Coventry for 16 years and as county commissioner for 12 years. These and other offices he relinquished when elected to congress. He has been medical examiner for Coventry and Andover since October, 1891 and is examiner for practically all leading incurance companies. For over 40 years he has been health officer for the towns of Coventry, Columbia and Andover.

Doctor Higgins feels that the greatest honor in his professional life came in 1906 when he was elected president of the Connecticut Medical Society. He was then 40 years of age and was at that time the youngest president the society had ever had. His outstanding accomplishment of his long political career which was under the republican banner was the passage of the law for the improvement of the rural roads. He introduced the first bill for this in the legislature in Jan 1925 and it was finally passed in 1931 allocating $3,000,000 annually for the work. Up to June 30, 1939, under that act the state had expended $24,000,000 or over $142,000 from each town for the improvements of its rural roads. Doctor Higgins assisted in organizing the Connecticut Rural Roads Improvement Association and was the first director for Tolland county. He is now secretary of the association which has as its present slogan "Keep Connecticut Out of the Mud."

Fifty years in the practice of medicine is a long time. To Doctor Higgins go our hearty congratulations. The Connecticut State Medical Society is proud of him.

* * *

DOCTORS OF DENTAL MEDICINE — A NEW PRODUCT AT HARVARD

Beginning with the fall of 1941, Harvard University will inaugurate a new five year course in its renamed School of Dental Medicine. Graduates in this new course will receive both the M.D. and D.M.D. degrees. This new development has been made possible by the gift of $650,000 from the Carnegie Corporation, $400,000 from the Rockfeller Foundation, and $250,000 from the Markle Foundation. A balance of $250,000 will be necessary to carry out the program but the University has full confidence in its ability to find the means of providing this balance. In addition, Harvard College has transferred to the resources of the new School of Dental Medicine $1,000,000 tentatively placed at the disposal of the Dental School ten years ago, thus bringing the permanent new assets for teaching and research in dentistry in Harvard to a total of $2,550,000.

Commenting on this change in the Dental School, President Conant says, "The new program contemplates a more complete and formal integration of dental and medical education than has heretofore been attempted in this country". Dental students will register in both the new School and in the Harvard Medical School, taking three and one-half years of the same medical courses as other students in the Harvard Medical School, and, in addition, one and one-half years of specific dental training.

This is the most radical step in the training of dentists yet attempted in the United States. According to the Committee on Economics of the American Dental Association, but twenty percent of the American people are adequately cared for by the 70,000 dentists now practicing. Instead of attempting to multiply the present provision for dental care by five in order to reach the other eighty percent, this Committee believes the real solution of the problem to be in advanced knowledge of the causes of dental disease, and resultant improvements in the methods of prevention of such disease. Retaining the skill and expertness attained under present methods of dental education, the new program will add to the dentist's equipment a wider and deeper knowledge of medicine, and hence a more comprehensive background for the advancement of study of essential causes and preventive method.

The new School of Dental Medicine plans to equip men to attack the manifold problems of dental medicine in private practice as clinical specialists of particularly broad training, or to teach the science of dentistry in dental schools, or to investigate and treat dental disease in hospitals and clinics. Dental education at Harvard will be brought closer in line with the methods and standards of medical training and will be in keeping with the swing of the pendulum toward the development of specialists in the broad field of medicine.

The day of the barbaric itinerant tooth puller is all but forgotten but to the specialists in any branch of medicine it would seem apparent that there is still a place for the "general practitioner" in dentistry. Several questions arise for which we await answers. Will the prospective students of dentistry be willing to devote the time required or be able to meet the financial demands of such a program? By a mere handful of clinical dental specialists can the existing 80% of persons lacking dental care be appreciably affected? Is there a probability that other dental schools will be sufficiently influenced to instigate similar programs?

Members of both the medical and the dental profession in New England will observe with interest the new developments from the Harvard plan.

* * * *

ALPHA AND OMEGA

The Bureau of the Census has published a new edition of the Physician's Handbook on Birth and Death Registration.

It should be studied assiduously by every physician in Connecticut. Not only does the Handbook advise to prepare birth and death certificates correctly but it shows the trends in vital statistics, and, as the editor of the New York State Journal of Medicine expresses it, the Handbook "points to the medical problems of the future."

The United States is rapidly becoming a country of elderlies. Thirteen and one-half years have been added to the average life span of the American population as a result of the substantial improvement in health conditions since the turn of the century. In 1901 the expectation of life of the general population in our country was only 49.24 years. In 1938 it was 62.78 years, a gain of 13.54 years or 27.5% of the original figure. As a consequence of this beneficial change, today the average person nineteen years of age has as many years of life remaining as the average child born in 1901.

Even though our total population has increased markedly in the last century, the birth rate has dropped steadily, and the problems attending the care of the aged are more numerous. Rejoice as we may because of the infant death rate reduced by one-fifth in ten years, and to the maternal death rate reduced by one-seventh in the same period, against these encouraging figures there stands out a rapidly falling birth rate, far outregistering the drop in the death rate.

To offset this unbalanced rate shall we offer our homes to the unfortunate children of Europe or shall we make of birth control a scientific program rather than an emotional crusade? It may be wise to adopt both plans.

* * * *

WAR TIMES ARE STRANGE TIMES

The Citizens Medical Reference Bureau, Inc., of 1860 Broadway, New York, which styles itself, "A National Organization Opposed to Compulsory Medication," has proposed an amendment to the Burke-Wadsworth Bill for compulsory military training which takes some kind of a prize. The amendment is:

"Provided that the men inducted for training and service as provided for in this act, shall be accorded the same freedom to choose the kind of practitioner and the method of healing of their choice which they were permitted to enjoy under the medical practice acts of the respective states prior to registration and that no applicant for registration or person so registered shall be subjected to disciplinary action or be penalized in any way for refusing to submit to any form of medical treatment which he regards as unnecessary and harmful except such physical examinations as are deemed necessary to determine physical fitness for military service."

The proponents of the amendment say that it offers an opportunity to prove that this country will not tolerate the use of compulsory military training as a vehicle for fastening compulsory medical totalitarianism upon the nation. The reason put forward is that it is well known that the practice of medicine is in the stage of experiment and discovery and is largely a matter of keeping up with the styles, and they go further to submit that more mental confusion and shell shock will result from fear of compulsory medical treatment than the destructive effects of bombs.

C. B.

* * * *

ELMCREST MANOR OFFERS NEW FACILITIES

It will be of interest to the physicians of Connecticut to know that Dr. Carl P. Wagner, Physician-in-Charge of Elmcrest Manor, reports the completion of a new addition to Marlborough House.

Twelve new bedrooms have been added, some with private bath, and a number of new bathrooms have been provided for Marlborough House proper. In keeping with the atmosphere of Elmcrest Manor these new rooms have been furnished with early colonial reproductions.

The new building also houses additional space for occupational therapy and physical education. Modern equipment has been installed for physical education classes. Occupational therapy facilities have been increased and a number of new crafts added. Miss Sarah Brown, who has formerly occupational therapist at the Austin Riggs Foundation in Stockbridge, Massachusetts, has been appointed Director of Occupational Therapy. Recreational and physical activities for women are carried on under the direction and supervision of Miss Margaret Munn and those for men under the direction of Mr. Charles Stepule. Facilities are provided for occupational therapy and a program of recreational activities throughout the day.

Under the direction of Miss Eleanor Cashman, R.N., Director of Nurses and Mrs. Clara Pendleton, R.N., Night Supervisor, adequate supervision and companionship are provided for the patients by a large staff of registered nurses and psychiatric aides. These people have been selected because of certain personality assets which make them particularly suitable for this type of work. A large proportion of the psychiatric aides hold college degrees.

These additional treatment facilities as well as therapeutic interviews with the physicians are provided for the patients at no additional cost. While the quality of service rendered at Elmcrest Manor has been steadily improved during the two and one-half years since it was established, the rates have not been increased. Doctor Wagner states that he will adhere to his original policy of providing a modern scientific sanitarium where mild mental conditions and personality disorders can be treated in pleasant surroundings at a moderate cost.

* * * *

NEW HAVEN HOSPITAL REVOLUTIONIZES OPERATING ROOM POLICIES

In the "Operating Policies and Procedures" as adopted by the New Haven Hospital may be found this clause:

"No one may assist in an operation unless he is a member of the staff of the Hospital and no charge shall be made for such assistance." This is indeed a revolutionary step in the management of any hospital operating room program. The same hospital has made it a rule that the time of starting an operation shall be understood as the time the incision is made, necessitating the presence of the operator at least twenty minutes before the listed starting time. Also, if the surgeon is late more than three times his cases will not be scheduled as beginning cases for one month, n other words, his cases must follow all other cases scheduled.

No hospital operating room, at least in this State, is run so perfectly that it does not have its difficulties with untrained assistants and tardy surgeons. The operating room policies of the New Haven Hospital may offer the best solution to these difficulties.

☆☆

COMING MEETINGS

September 2—6. American Congress of Physical Therapy, Cleveland.

September 12—14. Biological Photographic Association, Hotel Schroeder, Milwaukee.

September 16—18. American Association of Railway Surgeons, Chicago.

September 16—20. American Hospital Association, Boston.

September 17—19. 16th Clinical Congress, Connecticut State Medical Society, New Haven,

September 26—28. American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Excelsior Springs, Mo.

September 26—October 4. American Roentgen Ray Society, Boston.

October 6—11. American Academy of Ophthalmology and Otolaryngology, Hotel Cleveland, Cleveland.

October 11—12. Pan American Congress of Ophthalmology, Cleveland.

BLOOD PRESSURE? PRESTO!

You are always asking, "What's new?" The Taylor Instrument Co. answer with their introduction of a manometer cuff based on an entirely new time saving principle. Fits instantly all sizes of arms without twisting or slipping. For sale by The Professional Equipment Company. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

(SEE ALSO PAGE 2)

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

American Medical Association Questionnaire

Connecticut physicians who have not returned the medical preparedness questionnaire received from the American Medical Association are urged to do so without further delay. The latest information available shows that of 2598 questionnaires distributed in Connecticut only 1252 have been returned. The analysis and compilation of the data in these questionnaires will take some time and it is important that they be filed now. Additional copies of the questionnaire can be obtained from this office.

Medical Preparedness Program

Doctor George Smith, State Chairman of Medical Preparedness, has asked the presidents of each of the county medical associations to designate a county chairman of medical preparedness. These county representatives will constitute the State committee. Chairmen for the various committees have been designated as follows:

Fairfield	H. Bertram Lambert
Hartford	Donald B. Wells
Litchfield	Francis A. Sutherland
Middlesex	George A. Elliott
New Haven	Ralph E. McDonnell
New London	Daniel Sullivan
Tolland	Donald M. Beckwith
Windham	Edward J. Ottenheimer

The State Chairman on Medical Preparedness and the Executive Secretary had a conference with the Medical Preparedness Chairman of the Medical Society of the State of New York, Doctor Samuel Kopetsky, and the Secretary of the Society, Doctor Peter Irving, in New York on August 2, 1940. It is important that certain phases of the preparedness activities be coordinated with New York.

Revision of the Medical Practice Act

For some time it has been apparent to members of the Medical Examining Board that some changes in the Medical Practice Statutes are required. A sub committee from the Board, consisting of its Chairman, Doctor Bartlett, and its Secretary, Doctor Murdock, and the Executive Secretary of the Society, has been considering revisions to be recommended to the 1941 General Assembly. Before presentation to the General Assembly the amendments will be published in the Journal so that the physicians of the State may be familiar with the contemplated revision.

Committee to Study Statutes Regulating the Conduct of the Offices of the County Coroners

This Committee met at the Society's office on July 29th. There were present, the Chairman, Stanhope Bayne-Jones, Henry N. Costello, Louis P. Hastings, Albert J. Robinson and the Executive Secretary, Creighton Barker; absent, Edward H. Kirschbaum. Some of the preliminary steps of this Committee's activities had already been taken by the Chairman who presented an analysis of the statutes covering the offices of the coroner and medical examiner, and a memorandum discussing the application of these statutes had been prepared by Doctor Robinson. The next meeting of the Committee will be held early in September and during the interim studies will be made of statutes in other states.

Committee on By-Law Revision

The special committee authorized by the House of Delegates in May 1940 to revise the By-Laws of the Society is about to commence its consideration of the Society's By-Laws. These By-Laws as at present in force, were published in the August issue of the JOURNAL and any members who have suggestions to make concerning their improvement or revision are invited to communicate with Doctor D. Chester Brown, 330 Main Street, Danbury, who is the Chairman of the Committee on By-Law Revision.

Connecticut Hospital Association

Our congratulations go out to Bob Brough for the excellent new bulletin he is putting out for the interests of his fine hospital at Norwalk. On the chance that not all of the hospitals see this masterpiece, we are taking the liberty of presenting in this issue one of his articles in the July number. It is one of the best things we have seen written on the subject "Should the Hospital Be Open to Any 'Doctor'?"

> One of the intricate problems that hospitals face is the question of how liberal their regulations should be concerning the care of patients by doctors in the community or area served. Practice varies greatly. In large cities "closed" staffs prevail with membership restricted to doctors carefully selected on the basis of ability and personality. The closer the hospital approaches rural areas, however, the greater the tendency toward an "open" staff with privileges of one type or another being accorded to nearly all of the doctors in the vicinity. Voluntary community hospitals with "open" staffs are subject to requests of osteopaths, chiropractors and graduates of other so-called "schools of medicine" that they receive privileges similar to men who hold degrees from approved medical schools.
>
> The Board of Directors of the Norwalk Hospital, wishing to avoid any appearance of unfair discrimination, long ago endeavored to find a way of granting these requests, subject to proper restriction; but found that it could not do so because of very definite rules of the American Medical Association and the American College of Surgeons. These groups have insisted that any hospital recognizing other than graduates of approved schools of medicine will be denied recognition and the privilege of training interns. This means that if osteopaths, for instance, were permitted to treat patients within the hospital according to their own wishes, the Grade "A" Rating of the hospital would be lost because interns could not serve, and proper treatment of patients would, therefore, become impossible.
>
> The entire question is broader than a mere request to liberalize rules. It affects the safety of patients. For example, a large number of doctors, skilled to some extent in surgery, are not permitted to perform major surgical operations in the hospital because in the judgment of the Medical Staff and the Board of Directors they are not sufficiently trained for such vital and important work. Each doctor is, accordingly, given certain privileges within his ability or is assigned to certain departments of the staff where he can give patients excellent care according to his training and qualifications. To go contrary to the judgment of the Medical Staff in such matters would be taking a risk that the Board of Directors cannot properly assume.
>
> The entire subject is ably covered in the following quotation from a book recently published, "Legal Guide for American Hospitals," by Emanuel Hayt, LL.D, B., and Lillian Hayt, M.D., J.D., of the New York Bar:
>
> **"Right of Charitable Hospital to Restrict Medical Staff."**
>
> "In the formulation of its rules, a hospital may insist upon an adherence to their speciality by members of the medical staff. The visiting internist may be forbidden to perform surgery within the hospital; the surgeon, laryngologist or pediatrist may be barred from treating patients not covered by this field.
>
> "Without question, the hospital may exclude persons not possessed of an M.D. degree from treating hospital patients; only registered physicians and qualified registered nurses may be permitted to supervise the work done within the institution. Osteopaths, chiropractors and other cultists may be kept out; even those who possess a

medical degree need not be permitted to practice in the hospital if they are of questionable ability and uncertain ethics.

"In the majority of voluntary hospitals, the staffs are 'closed' rather than 'open'; it is the tendency of the court decisions to support the rights of boards of trustees to adopt by-laws or rules and regulations governing the eligibility of physicians to practice in the hospital. 'While standards of practice should originate with the medical or professional departments, the limitations, control, and execution must be in the hands of the governing board . . . Court decisions squarely place the responsibility on the board of trustees, with the assumption that professional qualifications and ability to meet the standards of practice in the hospital shall govern.'

"The hospital should have complete freedom to select its own staff so as to insure the highest standards. Under existing laws it is free to choose its staff wisely or foolishly; in so doing it commits no crime, although it may be held liable, civilly for its failure to select competent physicians and nurses. The Federal Government does not take the position that a hospital should open its facilities to every licensed physician regardless of his competence to practice, the size and special scope of the hospital and the other factors which normally influence a hospital's selection of its staff. Staff restrictions, for the purpose of raising the standard of medical care and to accommodate a given hospital's facilities or to carry out its dedication to a special field of service, unquestionably are proper and lawful."

In the June bulletin of the Hospital Association of Pennsylvania in an address by the President, Roger A. Green, he states, "In my opinion we have only scratched the surface of what our hospital association can do. We do not realize nor have we used all of our resources. In protecting the cause of the sick and injured we have a potential force of great weight if we organize all of our trustees, doctors, personnel, and best patrons of our hospitals." There is food for much thought in that paragraph.

Our Connecticut association has a great opportunity but first we must develop a spirit of mutual understanding, good will and cooperation among our institutions. One of the best methods to be used in accomplishing this objective would be the enlistment of the interest of all the members of our Board of Directors in the work of our Association and in the work of our hospitals connected with the Association. To do this requires the active interest of all of the superintendents. It is not enough that a superintendent should try to hold down his or her job in order to receive a monthly salary or that he should discuss with his Board of Directors the necessary matters pertaining to the operation of his own institution. It is necessary for every superintendent to realize that his institution is going forward much faster and is going to be a much stronger institution when all the members of his Board are intensely interested in what other institutions are doing to the point where they are willing to work cooperatively for the betterment of all the institutions of the state.

The State Legislature will be in session this winter and in order to secure legislation which will be of value to all our institutions and in order to combat legislation which will be detrimental to these institutions, we should have a group of the Boards of Directors of the various hospitals ready to go to Hartford at any time to do their share in presenting their viewpoints to the various legislative committees.

* * * *

ST. RAPHAEL'S HOSPITAL

Your editor had the honor of attending the dinner of the St. Raphael's Hospital campaign. Plans for the addition to the present institution have been prepared with the advice of Mr. Charles Neergaard, eminent New York consultant.

The old original building will be taken down. The addition will join the present hospital extending on Chapel Street to Sherman Avenue and south along Sherman. It will be five stories with a sixth story in front being an operating suite. The capacity of the hospital will be raised from 260 to 400 patients.

The first floor will be a new children's department with separate admitting ward, large solarium for recuperating children to play in, several isolation rooms, patients' library, and a waiting room. There will be private rooms two semi-private rooms, and three, four, five, and six bed wards.

On the second floor will be fifteen private rooms, twelve two-bed rooms, four five-bed wards and one four-bed ward; two large solaria, and three visitors' rooms.

The third floor, similar to the second floor, is for surgical cases. The feature of this design is flexibility. Many of the private rooms can accommodate two beds instead of one, allowing temporary expansion during emergency times.

The fourth floor is the maternity floor with a new delivery room, two nurseries, solaria, visitors' rooms, twelve private rooms, seven two-bed semi-private rooms, four five-bed wards, and one four-bed ward.

One of the features of the fifth floor will be a small segregated psychiatric suite for patients nervously or mentally disturbed. There will be small wards, seventeen private rooms, nine two-bed semi-private rooms and a solarium.

The sixth floor will consist of six operating rooms of various sizes, three anesthesia rooms, X-ray laboratory, and two cystoscopic rooms.

The anticipated cost of this new addition, which they hope to have completed within a year, is $1,250,000.

* * * *

BRIDGEPORT HOSPITAL

Following our article of several months ago relative to statistics of the Bridgeport Hospital showing patient days and costs by comparisons over a period of years, our attention wasdirected by Bartine to the A.M.A. Journal of March 30 in which they commented on these. We quote from the Journal:

> An increase in patient day costs from $1.32 in 1899 to $5.04 in 1939 is obviously of sufficient significance to warrant an attempt to discover and to analyze its elements. It is possible that such an analysis might provide some valuable assistance in planning for the costs of prepayment schemes of hospitalization in the future and might also reveal the causes responsible for this mounting cost.

Editor's Note: If the editors of the A.M.A. Journal were as familiar with hospital operation as the superintendents, they would realize that no study of Mr. Bartine's figures is necessary to determine the causes of mounting hospital costs.

* * * *

CHARLOTTE HUNGERFORD HOSPITAL

Miss Gertrude Voss, R.N., Superintendent of Nurses at the Charlotte Hungerford Hospital, took her vacation during the month of August. She spent it with relatives in various parts of Connecticut.

Miss Frieta Ritcey, Dietitian of the Charlotte Hungerford Hospital left on Aug. 13, by automobile to visit relatives in various parts of the Maritime Provinces.

Miss Alice N. Frank of Buffalo, N.Y., a graduate of the New York State School of Economics at Canton, N.Y., is serving as Relief Dietitian at the Charlotte Hungerford Hospital during the absence of Miss Frieda Ritcey and Miss Elizabeth Harrison.

☆☆

MEDICAL SERVICES FOR CIVILIANS

(*Continued from Page 508*)

5. Wilson, H.C. Wounds from bomb fragments (Letter to the Editor). *Brit. Med. J.*, 1940, 2: 66.

6. Jefferson, G. War wounds of the head. *Brit. Med. J.*, 1939, 2: 347-349, 407-410.

7. Lethem, W.A. Organization of the Emergency Medical Services I. Hospitals. *Brit. Med. J.*, 1939, 2: 656-658.

8. Frankau, C., The principles of treatment in gunshot wounds of joints. *Brit. Med. J.*, 1939, 2: 27-28.

9. Anon. Work of emergency hospitals. Casualties from Dunkirk. *Brit. Med. J.*, 1940, 2: 95-96.

10. Treatment of war wounds (Editorial). *Brit. Med. J.*, 1940, 2: 17-18.

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Paevex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE ALSO PAGE 2)

THE NATIONAL HEALTH PROGRAM A FRONT FOR SOCIALISM*

By Merle Thorpe

Editor, The Nation's Business

An influential group of people in these United States is trying very seriously to change the economic and political system inherited from our fathers. They are out to sell us a bill of goods which if accurately labelled would bear the old familiar brand of collectivism. They know, of course that in this instance informative labelling would kill the sale. People are too canny to fall for crude schemes to share the wealth and make "Every Man a King." So they have dressed the package up in a deceptive container and called it "liberalism." The sales talk includes some fine phrases such as "social justice" and "the abundant life."

In order to sell this package the salesmen of the new order must not only create a desire for it in the public's mind, but they must make us dissatisfied with the system we already have. That bit of strategy has been most obvious in the well organized agitation for change. All sorts of "deplorable" conditions were discovered. Americans who thought we had a great country, one relatively comfortable and happy, began to hear quite contrary assertions about one-third of a nation in misery.

The social revolutionaries were quick to see the possibilities for making capital out of the treatment of sickness. Here they could talk of saving the lives of babies, of smashing the "medical trust," of reducing the cost of hospital and medical care, of relieving the sufferings of patient, obscure people. Anyone who dared to oppose their great-hearted humanitarianism would be a Simon Legree or a Scrooge. It was good for votes. It promised new government controls that could be expanded toward that "democratic discipline" of which Rex Tugwell dreamed. In this cause they demanded State control of the healing arts. That is their objective, although it is to be attained, as usual, by devious routes.

To build up a case for more social controls, and at the same time to provide some variation from leaf-raking for the W.P.A., a national health survey was made. About $4,000,000 was spent canvassing families to determine the amount of disabling illness and the extent to which it had received medical attention.

Out of this survey later came a mass of statistics. They were poorly put together, as might have been expected from 6,000 W.P.A. workers without training and suddenly impressed into the highly technical task of assembling medical data for statistical analysis. The areas surveyed, it is believed, did not represent a fair cross-section of the population. They were heavily overweighted by the large urban centers. As usually happens with research undertaken to prove a preconceived view, the attempt to extend figures so compiled produced questionable conclusions.

Nevertheless these "scientific" data made a good front for the National Health Program, which originally contemplated the spending of $850,000,000. And the ill-housed, ill-fed, ill-clothed third became also ill-doctered.

The remedy proposed was in terms of the familiar New Deal formula for all shortcomings of body and spirit. Spend a lot of money. Give more power over the lives of the people to the executive branch of the Government.

Now, as every doctor and dentist and every hospital administrator knows, health cannot be purchased with money under any and all circumstances. You cannot legislate it at so much a head nor insure it by making the thrifty disgorge their savings for the benefit of those who have less than they want. In medical care and hospitalization, quality is more important than quantity.

It doesn't take $4,000,000 and 6,000 W.P.A. workers to refute the false implications of the national health survey. Anyone reasonably curious about the facts and sufficiently objective of mind to interpret them will find that health is better in the United States than ever in its history. This applies to practically every index.

Since the beginning of the century the span of life has been increased by 12 years. Infant and maternal mortality rates are lower than ever before. The ravages of tuberculosis, typhoid, diphtheria, pneumonia and other dread afflictions are decreasing.

Dr. Haven Emerson of New York, well

---

*Reprinted from Hospital Reporter and Guide (July 1940) by permission of the editor.

known public health authority, has testified that health has improved rather than declined during the great depression. Children are as tall, as heavy and as active as they were in 1929. There is less malnutrition.

Good health is a relative matter and always will be. No amount of emotional crusading will solve every problem in this generation and leave a legacy of perfection to the next. Even if that were possible, we could do nothing quite so demoralizing to our posterity. Compared with earlier periods and with all the great nations of the world we are better off as regards health and the care of physical affliction. Let us not be content with what we have done. We must go forward, but step by step, restraining those whose irrational zeal for change would hazard all that has been gained so far.

The basic weakness of the reform mind has been so well stated by the sociologist, Lester Ward, that I cite his warning:

"The whole difficulty with the discussion of social questions has always been this haste to deal with the end, this impatience with everything that relates to the means. The fact is that the end can be attained only through means. All attempts to reach the end directly are destined to fail."

That's why the heated concern of the Administration with shortcomings in the distribution of medical care is misplaced. It is in the position of a physician who would prescribe aspirin for a pain in the stomach. Insofar as there are shortcomings that can be corrected, the Government would show more results by treating causes rather than symptoms. The causes that it can treat are economic. It can give jobs to the unemployed, not directly but through the means of commerce and industry, by ceasing to harass business men as public enemies and by positive actions that will inspire confidence in business to expand and develop. It can remove a mass of artificial restrictions on free production and distribution of goods and services. These are proper functions through which government can smooh the way of life for its citizens.

The admirable work of the medical profession, the hospitals and other private agencies to relieve pain and conserve life deserve unstinted applause instead of the mass of inspired criticism aimed at them. Right now, from 10 to 15 per cent of the people receive free medical service in their homes or in doctors' offices. Approximately 30 per cent of physicians' and surgeons' services in hospitals are rendered gratis. The contribution of the profession has been conservatively estimated at one million dollars a day.

In every community the indigent have various facilities for treatment whether or not they can pay for it. They do not need nor want compuslory health insurance. In a day when the organized medical profession is reviled from political platforms, when the American Medical Association is under criminal indictment by the Federal Government for daring to maintain ethical qualifications for its membership, we should remember that group medical practice, group hospitalization and health insurance are not creations of the reform junta in Washington. They were being experimented with by private organizations long before the Interdepartmental Committee launched its vast schemes for perfect health.

For the moment those cosmic plans are in abeyance, sidetracked for the Wagner Federal hospital bill only because there seemed to the master minds no immediate prospect for passage of the more ambitious measure. A great national shortage of hospital facilities is alleged. Notwithstanding that we have on the average some 200,000 unoccupied hospital beds, it is proposed to build another 180,000 or so—with money the Government must borrow.

The need for any more spending in this direction is unanswerably challenged by the Rev. Alphonse Schwitalla, president of the Catholic Hospital Association. He reminded the Administration-packed National Health Conference in Washington that there remain only 13 counties in the whole United States, no portion of which is within 30 miles of a general hospital. All but 1.5 per cent of the population are within an hour's drive of a hospital, and facilities are rapidly being extended to reach the remainder.

Before the Federal Government proceeds to build any more hospitals some thought might be given to what is to be done with its great chain of veterans' facilities when the peak of war veteran admissions is passed. And to how communities that are handed federal hospitals on a platter are going to support them.

It is vitally important to the hospitals that private philanthropy in this country shall not be extinguished. This is an inestimable asset but it cannot survive the competition of paternalistic government. Largely through its means, the nation's capacity has been increased in 10 years by some 300,000 beds.

Dr. S. S. Goldwater, superintendent of Hospitals in New York City, has pointed out that approximately half the hospital patients in his city have been receiving care at the taxpayers' expense. The proportion is steadily increasing and now tends to be nearer 70 per cent. With federal aid he expects it to go still higher.

Can we contemplate with equanimity a situation in which hospitalization for everyone becomes a public responsibility? Already many who could pay receive it free. The word is going around that only saps and plutocrats pay hospital bills. With open season on plutocrats, and saps rapidly learning their way around in a "gimme" society, the private pay patients are likely soon to be negligible.

The program for socialization of medicine and all its facilities is only one manifestation of the most shocking reaction of this age—the abandonment of free institutions for authoritarian controls. Every move is clothed in the sheepskin of humanitarian reform. Behind this "democracy" imported from Europe stand a set of masters eager to use on our millions those new instruments of power designed to make over the nation in the image of the superman.

The Doctor's Office

THE DOCTOR'S OFFICE

Stanley R. Dean, M.D., announces the opening of offices for the practice of neurology and psychiatry, 31 Third Street, Stamford, Conn.

Arthur B. Sullivan, M.D., announces the opening of an office for the practice of general medicine, 29 North Main Street, West Hartford.

Paul H. Twaddle, M.D., announces the opening of an office for the practice of internal medicine, specializing in cardiology, 179 Allyn Street, Hartford, Conn.

-The- General Practitioner's Forum

During the past few months, many articles dealing with surgical emergencies have appeared in the literature. Shock, Pulmonary Embolism, Burns and Fractures have been thoroughly discussed. On the other hand, the purely medical emergency has had little attention. That a need exists for such papers was emphasized, following a survey of several hundred deaths that occurred in four hospitals. Although the case records showed that many diseases were involved, the terminal medications were invariably cardiac and respiratory stimulants plus the inevitable oxygen. At the risk of being accused of second guessing, it does seem that, excluding the obviously hopeless patient, something could have been done for some of the others. With that end in view, several leading clinicians were canvassed for pertinent data. What follows is a brief summary of their replies.

A comprehensive paper dealing with the newer methods of handling the medical crisis would be definitely valuable.

As early recognition of the pathological processes involved lends itself to specific treatment, more autopsies must be performed. There is a great deal of room for improvement in the interpretation of the clinical and necropsy findings.

Close observation of every detail in the care of the patient will anticipate and often forestall the emergency.

Specific treatments clinically proved and recommended are as follows: (1) *Pulmonary Edema* from right heart failure in pneumonia, toxic myocarditis or congestive heart disease, treated with phlebotomy, intravenous injections of 2 cc. of a mercurial diuretic, and the usual stimulants; (2) *Diabetic Coma*-aggressive treatment is essential; 1000 cc. of 5% glucose and normal saline containing 100 units of insulin — more if needed — should be given immediately. This should be followed by more fluids and hypodermic insulin. Acidosis may be checked by giving sodium lactate. (3) *Anuria and Uremia* complicating acute nephritis-repeated phlebotomy of 100 to 200 cc. followed by daily transfusion of 100 cc. of concentrated human serum or normal serum if the other is unavailable; (4) *Coronary Thrombosis* and *Pulmonary Embolus* are often hard to distinguish clinically. Fortunately both are treated alike; inhalations of 100% oxygen and intravenous injections of one-half grain of papaverine and one-seventy-fifth grain of atropine dissolved in 10 cc. normal saline; (5) *Carbon Monoxide* and *Illuminating Gas Poisoning* are treated by phlebotomy—up to 500 cc.—transfusions of whole blood, methylene blue intravenously and by mouth, nicotinic acid intramuscularly and by mouth.

* * * *

Subcutaneous implantation of sterile tablets of estrogenic hormones may soon become a definite clinical procedure. Of these substances testosterone has had the more complete study. Preliminary reports based on a definitive number of cases are promising. Without other medication benefits lasting from three months to a maximum of fifteen months were observed before new implants were needed. As sterile 150 mg. tablets of testosterone are available for experimental purposes, a simple technique of implantation is as follows: with sterile precautions and using local anesthesia make a one inch incision on the abdominal wall-preferred site —; then make a pocket deep in the subcutaneous fat large enough to accommodate the inserted tablet; then close the incision. Keep a clinical record of the progress of the case. These are submitted to the company supplying the tablets.

* * * *

Some time ago we reported the use of small doses of sulfanilamide and local application of gentian violet as a cure for Vincent's Angina. Except for the stain, it has been an efficient treatment. Word now comes that an English investigator assuming that Trench Mouth was a pre-pellagrous state, cured the condition with doses of Nicotinic Acid — 100 mg. four times a day.

T.P.R., M.D.

Our Neighbors

MASSACHUSETTS

Massachusetts reported 62,382 live births and 1730 stillbirths, a total of 64,112 for the year 1938. Of these 50,888 were reported as occurring in hospitals. There were 2216 cesarean sections performed and 16 hysterotomies, a total of 2232 abdominal deliveries, or an incidence of 1 in 28.7.

* * * *

NEW YORK

The Council Committee on Medical Preparedness of the New York State Medical Society and a large number of representatives of the sixty one county medical societies met at Albany on July 29. At this meeting a general plan of organization was adopted for the registration of physicians, and a program was proposed whereby the medical interests both of physicians and of the people of the several counties might be supervised by the local medical societies. The following day at The Academy of Medicine in New York City the health, nursing, hospital, and medical resources of the state were surveyed at the request of the State Coordinator for National Defense by the Legislative Commission to Formulate a Long Range Health Program. Thus, the integration and teamwork necessary to the medical aspects of the national defense are already under way.

Approximately four hundred physicians of Weschester County have applied for registration under the new plan of medical welfare administration which became effective June 15. The plan has been accepted by the County Department of Public Welfare and by a number of the local town and city departments. A feature of the plan is the joint committee of physicians and welfare workers which is to administer the program generally and to act specifically upon complaints and problems arising between welfare clients, physicians, and welfare officers.

According to Health News, prompt and adequate response by the practicing physicians of upstate New York to the new law requiring the reporting of cancer is evidence of the first successful venture of its kind anywhere in this country and probably in the world. Over 12,000 reports of cancer cases have been received by the department's Division of Cancer Control since January 1, 1940. The number of cases reported compares favorably with results obtained in the past by means of expensive special surveys made to procure similar data and the reports are of much greater scientific value since, for the most part, they are accompanied by data from the pathologic laboratory regarding the microscopic character of the tumor.

Estimates based on current experience indicate that the New York City Department of Health will spend $100,000 less for pneumonia serum in 1940 as the result of the discovery of sulfapyridine. It is expected however that serum treatment still will be necessary in many cases.

By the passage of the Page-Milmoe and Mahoney-Todd bills it will now be more difficult for graduates of inferior schools in other states to intern or practice independently in New York State. The Page-Milmoe bill requires applicants from elsewhere to have had equivalent training and to have passed an examination comparable to the one given in New York State. The Mahoney-Todd bill forbids hospitals to employ graduates of colleges not recognized by the Board of Regents and requires clinical clerks in hospital wards to be bona fide students of approved medical schools.

* * * *

RHODE ISLAND

For the fifth consecutive year the Trustees of the Fiske Fund of the Rhode Island Medical Society did not award a prize for the Fiske Fund Essay. The Editor of the Rhode Island Medical Journal, in explaining this situation, expresses the belief that either the members of the Society are so prosperous that a premium of $250.00 has no appeal for them or the state of general medical lassitude is more prevalent in that community that was suspected. The Trustees of the Fiske Fund have announced a prize of $250.00 for an essay to be submitted in 1941 with the title "The Surgical Treatment of Peptic Ulcer."

- NEWS -
from County Associations

Fairfield

Doctor H. LeBaron Peters died at his home on Friday afternoon, August 2, 1940, from coronary thrombosis. Except for brief rests necessitated by similar attacks during the past few years, he remained at work until a few days before his death. The growth of the laboratory of the Bridgeport Hospital in its contribution to medical practice in the fields of pathology, chemistry and bacteriology, and more recently in the work of the tumor clinic has been a tribute to his integrity and vision. The younger men have been particularly indebted to Doctor Peters for encouragement and for little kindnesses of which they often were not aware.

The loss of such a man is one which the profession and particularly his colleagues in Bridgeport can ill afford.

The Semi-Annual Meeting of the Fairfield County Medical Association will be held on Wednesday, October 2nd, 1940. There will be golf, tennis, quoits, and horse-shoe pitching for those interested at the Mill River Country Club, Stratford, Conn. The business session will be held at 5 o'clock at Laurel Heights Sanatorium followed by dinner at 7 p.m. The scientific program will be presented by Doctor E. J. Lynch, superintendent of the sanatorium, and the members of his staff.

Doctor Frederick M. Bannon was recently made a diplomate of the American Board of Otorhinolaryngology.

Doctor Vogle A. Paul has been appointed to the regular Surgical Staff of the Stamford Hospital, and Doctor William D. Troy was named to the Associate Staff of the hospital.

* * * *

Hartford

A Community Rehabilitation Workshop program has been started recently in Hartford through the combined efforts of the Connecticut Society for Crippled Children and the Hartford Tuberculosis and Public Health Society. The shop will serve arrested tuberculosis cases and those with orthopedic difficulties. Financing will be effected through Easter Seals, Christmas Seals, the President's Birthday Ball and the local community chest.

Doctor William W. Wright, Travelers Insurance Company, Hartford, received a prize at the third annual exhibition of the American Physicians' Art Association for his "Polish New England," an oil showing highest creative ability.

* * * *

Litchfield

Doctor James Douglas Gold, president-elect of the State Medical Society, is spending a vacation with his family at Cream Hill, Conn. Doctor Gold is a member of the original family who settled Cream Hill in the 1700's and is named for the first white man ever to spend a winter in Cornwall.

Doctor Daniel O'Brien, Representative of the Rockefeller Foundation and a native of Torrington, after spending a short vacation in the United States, took off on the Clipper Ship for Vichy, France. The first two stages from New York to Lisbon, and from Lisbon to Barcelona were by the air route. From Barcelona he took the train to Marseilles, thence by train to Vichy. Doctor O'Brien will study Health and Sanitary conditions of the civilian population of France.

Doctor and Mrs. Mark Fleming recently visited the Charlotte Hungerford Hospital. They are spending the summer at Pleasant Valley. Doctor Fleming was formerly Medical Superintendent of Bellevue Hospital and retired from the position of Deputy Commissioner of Hospitals of New York City in 1936. Mrs. Fleming, née Miss Marion Rottmen, was Superintendent of Nurses of Bellevue for many years. The Flemings now reside at Fruitland Park, Florida.

Middlesex

Doctor John T. H. Powers has opened an office in the Central National Bank Building in Middletown, limiting his practice to diseases of the eye, ear, nose and throat.

The annual outing of the Central Medical Association was recently held at Sheriff Thompson's bungalow in Haddam. The afternoon and evening were given over entirely to sports such as soft ball, target shooting and filling inside straights.

Doctor Louis O. LaBella, chief of one of the surgical services and major of the medical detachment of the Connecticut National Guard, is on active duty in New York State.

* * * *

New Haven

Doctor Francis G. Blake, acting dean of Yale University School of Medicine, has written an article together with Doctor James W. Haviland of Baltimore on "Parenteral Administration of Sulfapyridine," published in American Journal of the Medical Sciences, March, 1940.

Doctor Dennis O'Connor of the Yale University School of Medicine presented a paper on "The Orthopedic Aspects of Radium Poisoning" before the Boston Orthopedic Club on April 8.

——☆☆——

The death rate from tuberculosis for the entire United States for 1938 was 48.6 per 100,000 population which is 9.3% below that of 1937 and the greatest single annual decline in three decades, except for the phenomenal fall in the death rate just after the war in 1918. This figure was obtained by direct correspondence with health officers of various states. J.S. Whitney, Amer. Rev. of Tuber., Aug., 1939.

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

(SEE ALSO PAGE 2)

Proceedings—Annual Meeting House of Delegates

of The Connecticut State Medical Society

May 21, 1940

The 148th Annual Meeting of the House of Delegates was called to order at 10:05 a.m., May 21, 1940, by the President, Joseph I. Linde. The roll was called by the Secretary and a quorum declared present. The reports of the Chairman of the Council and of the Secretary were then read and accepted (see Journal, Vol. IV, No. 7, pages 423-426). The Treasurer's report (Journal, Vol. IV, No 5, pages 285-289) was then read and accepted later after the report of the Auditing Committee was read. The reports of the Committee on Permanent Funds, Editor of the Journal, Legislative Secretary and Committee on Public Policy and Legislation, Committee on Medical Examination and Education, Committee on the Clinical Congress, Tumor Committee, and Committee on Public Health were all accepted as printed (Journal, Vol. IV, No. 5, pages 289-296). The report of the Committee on Medical Expert Testimony was read by the Secretary and accepted.

REPORT OF COMMITTEE ON MEDICAL EXPERT TESTIMONY

Your Committee begs to submit the following report:

In the past year your Committee has continued to function. At the present time we are considering with the Special Committee of the Connecticut State Bar Association a bill on expert medical testimony which was drafted after several years of study by the Special Committee on Medical Jurisprudence of The Association of the Bar of the City of New York and representatives of the Medical Society of the County of New York, the Medical Society of the State of New York, The New York Academy of Medicine, and the combined group of medical societies of Greater New York. This bill, copy of which is attached, embodies several features with which your Committee is in accord.

It is desirable that any proposed act in relation to expert medical witnesses shall have the support of the State Bar Association.

It is our hope that a suitable bill may be proposed at the next meeting of the General Assembly.

Respectfully submitted,
OTTO G. WIEDMAN, Chairman

The reports of the Committee on Cooperation with the Yale School of Medicine and the Committee on Narcotic Drug Addiction were accepted as printed (Journal, Vol. IV., No. 5, pages 298 and 297, respectively). The report of the Committee on National Legislation (Journal, Vol. IV., No. 5, pages 291-292) was accepted with additions read by Dr. Blumer. In the discussion of this report the Secretary contributed the following information:

"Another thing that is occurring is one of these cult activities, where the chiropractors are now seeking the right by Congressional action to give medical service, first aid service, under the United States Compensation Laws. This privilege was granted to the osteopaths about three years ago — I think it was fairly recently — by an odd sort of a fluke that no one understood very well at the time. But anyway, they got away with it. And now the chiropractors are seeking the same privilege. With the increase of Federal employment, which includes all the workers on the W.P.A., the P.W.A. and all those things, the extent of the activities of the United States Civil Service Commission and the compensation under it is broadened, so that there are now many millions of people who are exposed to the care given by the United States Compensation Commission. We have been in personal touch with all of our representatives in Congress and in the Senate, asking their opposition to this move. Its present status is that it has been referred to a sub-committee of Congress for further study. Mr. Miller, our own Congressman, I believe from this district, was on the committee that heard this. It was brought to his attention and it appeared from the correspondence that he was at least cognizant of our ideas with respect to it."

Doctor Nahum at this time requested the opinion of the Committee on National Legislation on the Wagner-George bill. Dr. Blumer's reply: "I think it would be fair to say that we don't see anything particularly disadvantageous about the bill. We do think that it throws a great deal of responsibility upon the Surgeon-General of the Public Health Service and we mentioned that in the report, but it is difficult to see how that could be avoided because someone has to have the responsibility, and perhaps the Surgeon-General of the Public Health Service is as adequate a person as could be gotten. But I don't think there is anything very antagonistic to the interests of the medical profession in the bill, and I think Dr. Steiner felt the same way."

The reports of the Committee on Workmen's Compensation, the Committee on Industrial Health, and the Committee on Public Relations were accepted as printed (Journal, Vol. IV, No 5, pages 299-298 and 295, respectively). Doctor Lambert, Chairman of the Committee on Hospitals, then read his report, and it was accepted as read. The report of the Advisory Committee to the Nursing Examining Board was read and accepted (Journal, Vol. IV, No 5, page 298).

The reports of the Committee to Study Osteopathic Legislation and the Committee to Study Prepaid Medical Service were then read and accepted. These reports follow:

COMMITTEE TO STUDY OSTEOPATHIC LEGISLATION

Mr. President and Gentlemen of the House of Delegates:

This is the first time the osteopathic situation has been presented for Committee study. The problem is so involved that only general conclusions can be drawn.

Osteopathy is not defined in the Connecticut Statutes. According to Webster's New International Dictionary, it is "a system of treatment based on the theory that diseases are chiefly due to deranged mechanism of the bones, nerves, blood vessels and other tissues, and can be remedied by manipulation of these parts."

Osteopathic schools are proprietary enterprises. Teaching facilities and clinical material, in proportion to the size of the student body, compare unfavorably with the standard of medical schools, according to a publication of the Kansas State Medical Society. No such school is connected with a university, nor recognized apparently by official accrediting agencies for universities and colleges. Requirements for entrance include high school graduation but not academic pre-medical training. Pre-clinical courses cover the basic sciences. Clinical courses major in osteopathic subjects, with a minor consideration of surgical diagnosis, technique and treatment, and usually no course in medical procedures, except as this would be included in clinical osteopathy.

Connecticut State law requires an osteopathic graduate to be examined by the Board of Healing Arts in the basic sciences. He must then be examined by the Osteopathic Board before licensure. If he wishes to practice medicine or surgery, or both, he must pass an examination before the Medical Examining Board.

Laws in the forty-eight states and District of Columbia vary considerably. However, a general grouping may be made as follows: first, in nineteen states and the District of Columbia, the osteopath is examined by the same board as the doctor of medicine. The license in some of these states is the same granted to the doctor of medicine; in others it is limited in medical and surgical privileges and in still others it is restricted to practice of Osteopathy. Second, in twenty-nine states, including Connecticut, the osteopath is examined by a board of osteopathic examiners. Four of these states, including Connecticut, allow further examination by medical examining boards for license to practice medicine and surgery. In five others, special qualifications, such as internship and further examination lead to license to practice surgery but not medicine.

Many state legislatures are being asked to liberalize state laws. These changes are being sponsored by the National Osteopathic Organization. Local osteopaths who were interviewed, have little interest but admit paying an assessment for the program. The more recent graduates seem to feel that their education has been broadened to encompass all fields of medicine. The facts do not bear this out.

There appears to be no urgent need for more practitioners in Connecticut. Some two thousand doctors of medicine, together with thirty-five general hospitals are licensed in our state. There are at present only eighty-two osteopaths practicing in Connecticut.

It would appear that, in the interest of the public good, the Connecticut Statutes are sufficiently liberal in regard to osteopathy at the present time, and in the opinion of your committee the Connecticut State Medical Society should oppose any change in the present law.

B. M. PARMELEE
Chairman

REPORT OF THE COMMITTEE ON PREPAID MEDICAL SERVICE

Samuel C. Harvey, Chairman
Daniel P. Griffin
James R. Miller
Thomas P. Murdock
Oliver L. Stringfield
Creighton Barker (ex-officio)

The Committee on Prepaid Medical Service authorized by the House of Delegates last year has met repeatedly and has had two conferences with non-professional groups who were in a position to give it needed information. However it is not as yet prepared to present to you anything more than a report of progress.

The members of the committee were of course from the start in agreement that any prepaid medical service receiving the endorsement and support of this society must ensure the full choice by the patient of the physician, and the reimbursement for his services must be fair, prompt and certain. They were also in agreement that any recommendations made for your action must be sound and based upon as accurate and detailed knowledge as could be obtained. Such data in detail as a matter of fact are not available here nor elsewhere, for while many plans of this nature are on paper, but few have been in action long enough to give significant data, and these latter have not been made available in suitable form for our purpose.

The analagous but far from identical prepayment plan for hospital care (non-professional) has been here and elsewhere in effect long enough to have emphasized the importance of certain aspects of the problem. The more important of these are the necessity of enrolling subscribers in sizable groups in order to get a fair distribution of risks, and the importance of holding the costs of "selling" and collection to a minimum by working within employee groups. Such has been the essential backlog of successful hospital plans and in the opinion of your committee must be of any sound plan of prepayment for medical care.

Having arrived at this point of view it seemed essential for the committee to know whether or not employers of labor in considerable groups saw any need or desirability for a prepayment plan for medical care, for without their sympathetic approval it would be difficult to enroll subscribers or to make collections in such a manner as to make the project feasible. Consequently your committee met with a group of twelve employers and from them obtained the impression that any plan proposed by the Society would meet with the same support and cooperation as had the Hospital plan, provided that it caused no more administrative burdens than this had done. Some, but not all, were certain that there would be a demand for such an extension of the repayment principle to medical care, while as a whole, they were sympathetic with it.

Your committee then conferred with six employees in representative employee groups who were in a position to know the reaction of the employed. Considered in general it was felt that there was very definitely a demand for something to cover the costs of medical care analagous to the prepayment plan for hospitalization, but how great this might be when balanced against possible costs, was indeterminable. They were of the opinion, however, as were the employers, that if such were done, the costs must be kept as low as possible in order to meet the needs of the larger number, who did not find it possible to purchase sufficient coverage from the corporate carriers of insurance. As a result of this, it seemed advisable for your committee to hold a conference with representatives of corporate carriers and discuss with them the possibility or advisability of their attempting to offer coverage at a cost sufficiently low to make it salable to low income groups. Such a meeting is projected for the near future.

It has become increasingly apparent from these discussions that the factor of cost is all determinate. Set too high it will sell only in a limited way among a high income group who can purchase such protection at present, set too low service becomes restricted in quantity or quality or both and financially unsound. However the lower the cost the greater potential market and consequently a greater spread of risks and a lower cost of administration.

An effort has been made by your committee with the assistance of Dr. Watkins a statistician, of Yale University, and certain members of the Society to ascertain the costs in a fairly large group of patients (approximately 780) who had been hospitalized under prepayment hospital plans. Certain essential medical data were transcribed, so that a rough concept of the patient's illness might be obtained and such transcriptions sent to at least four physicians, skilled in the care of the particular ailments concerned, and they were asked to estimate the proper charge for a semi-private category of medical care, which is the category covered by the prepayment hospital plans. These estimates were analyzed statistically, and the impression was gained that medical care in the hospital subject to the same limitations as to duration and coverage as obtains with prepayment for hospitalization itself, would require approximately the same yearly costs to the average family of four as does the latter, namely roughly thirteen dollars, or twenty-six dollars for coverage of the costs of hospitalization and medical care incurred by it. Certain plans which attempt to give in addition to these home office care range from $48 to $78 per year. It is however the domicillary and ambulatory costs that carry one into a field exceedingly difficult of control, peculiarly susceptible of abuse by both the patient and physician, and for which there are no adequate data.

Your committee has then arrived at no definite recommendations and only conclusions to the effect that there is a need for some voluntary prepayment plan for medical care and that it is probably feasible to devise such, at least for the moment as regards medical care in the hospital, and that continuing consideration of the whole subject is desirable.

REPORT OF MEDICAL EXAMINING BOARD

Mr. President and Gentlemen of the House of Delegates:

The Connecticut Medical Examining Board admitted to its examination during the past year two hundred applicants. Of this number one hundred sixteen took the written examinations and eighty-four were admitted to the examination on the basis of credentials. There was a total of sixty-eight failures or thirty-four per cent. Three osteopaths appeared for examination during the year: two wrote medicine and one wrote medicine and surgery. Two failed and one was successful in surgery.

Respectfully submitted,
T. P. MURDOCK, Secretary

The Committee to Revise the Medical Practice Act of Connecticut reported progress. This report was accepted and the committee continued.

The report of the Program Committee was read by the Secretary and accepted with thanks.

The report of the Delegates to the Vermont State Medical Society was accepted as printed (Journal, Vol. IV, No. 5, page 299).

The report of the Delegate to the Connecticut Pharmaceutical Association was accepted as printed (Journal, Vol. IV, No 5, page 295). Dr. Barker discussed the report as follows:

"Mr. President, on page 295, in the report of the delegate to the annual meeting of the Connecticut Pharmaceutical Association, at the last of the first paragraph, the last sentence of Dr. Dayton's report reads: 'I have the impression that some of the pharmacists feel this Act was supported behind their backs by our Society.' I don't know whether any of you read that report, but I rise to correct that impression. The Connecticut State Medical Society said nothing, yes or no, with respect to the passage of the Pure Food and Drug Act; and as has already been pointed out, this is not in the Department of Health. It is in the Department of Food and Dairies. There is a rather complicated administration there. The Commissioner of Agriculture has some of it, and the Commissioner of Dairies has some more of it, but there is none in the Department of Health. This Society, through its legislative committee, made no appearance, either for or against the passage of this bill. It brings into effect in this state a law which is practically identical with the Federal law, which only becomes fully effective on the 1st of July of this year. And this law in Connecticut only becomes fully effective on the first of July of this year."

Dr. Miller gave a report for the delegates to the Medical Society of New Jersey and the report of the delegate to the Medical Society of the State of New York was read by the Secretary. Both these reports were accepted.

After a short recess the House of Delegates proceeded with the next order of business and elected the officers, delegates to State Societies, and committees as printed in the agenda. The House of Delegates then adopted the recommendation of the Council that "the invitation received from the Fairfield County Medical Association to have the 1941 Annual Meeting of the Society in Bridgeport be accepted."

The recommedation of the Council was adopted that the President appoint and designate the chairman of the 150th Anniversary Committee to make arrangements for the Sesquicentennial of the Society in conjunction with a Committee on Arrangements appointed by the Middlesex County Medical Association.

The recommendation of the Council approving the formation of a Section on Proctology was adopted, also the recomendation of the Council accepting a resolution from the Fairfield County Medical Association approving the program of the National Physicians' Committee for the Extension of Medical Service.

On motion of the Treasurer. Doctor Miller, it was voted to postpone the levying of dues for 1941 until a meeting of the House of Delegates later in the year.

The report of the Conference Committee with the Nursing Examining Board, after some discussion, was laid on the table.

Proposed amendments to the by-laws were then read, following which the House of Delegates adjourned for lunch.

* * * *

The afternoon session was called to order at 1:45 p.m. by President Linde.

The recommendation of the Secretary was accepted that a committee be appointed by the Council to study and recommend revision of the Society's by-laws and report to the House in 1941.

The recommendation of the Legislative Committee was accepted that the Council appoint a committee of three to consider the laws covering the operation of the coroners' offices.

Doctor Blumer, delegate from New Haven County, then read the following resolution, presented by request:

"*Whereas*, at the meeting of the House of Delegates of the Connecticut State Medical Society held on May 25, 1932 a resolution was adopted advocating the amendment of Section 6246 of the General Statutes of Connecticut to permit physicians to prescribe the use of contraceptive devices by married women in this state; and

Whereas the Supreme Court of Connecticut has now construed said Section 6246 to preclude the prescription and use of any contraceptive device within the state;

Therefore be it Resolved that the Connecticut State Medical Society shall present to the 1941 session of the General Assembly of Connecticut for adoption at that session an amendment to said Section 6246 which will permit physicians to prescribe the use of contraceptive devices for the use of married women where the prevention of conception is necessary by reason of the condition o the health of the patient."

Discussion on this resolution followed.

"President Linde: You have heard this resolution, what is your pleasure?

Dr. W. M. Shepard: I move we pass favorably upon it.

Dr. F. S. Bird: I second the motion.

Dr. McDonnell: May I ask a question? Is that from New Haven County or from New Haven City, from which society?

Dr. Blumer: It is from neither. It was handed to me with the request that I present it. As far as I know, it was handed to me by a friend of mine who asked if I would present it as a delegate, and I agreed to do it. To tell you the honest truth, I don't know what the course is.

Dr. Murdock: Is the motion now under discussion?

President Linde: Will you repeat the resolution? (Secretary Barker repeated the resolution).

President Linde: This motion has been moved and seconded. It is now open for discussion.

Dr. Murdock: Mr. President, in order that the record will be clear, I am discussing this resolution as an individual member of this Society and an uninstructed delegate, and not as the Councilor for New Haven County. I believe that we could stay here for weeks and perhaps for months discussing this subject as to whether or not it was sound scientifically, morally or economically. There are those of us who believe that it is sound scientifically, economically and morally. There are those of us who believe that it is unsound scientifically, economically and morally. But there is one place, I believe that we can all agree, and that is that this subject is and has been a controversial one. The immediate past history of this resolution or similar resolutions goes back to about 1931 when the House of Delegates voted to recommend such legislation. About 1932 the committee on Public Policy and Legislation recommended to the House of Delegates that such action be taken, and no action was taken on that subject at that time. It is known that for many years the Legislature has been in disagreement on this subject, and only recently, according to the press, the Supreme Court itself was in disagreement with a split decision on the subject.

Now, there is in our membership about thirty per cent who are communicants of the Roman Catholic Church. These men, by virtue of their early religious training and subsequently their scientific training, cannot accept that this issue is scientifically sound, morally sound or economically sound. And so we can meet here and accept, I think, that this is definitely a controversial subject.

In order that you may know just what you are voting for, I think you should be told the history of this resolution presented by Dr. Blumer. And for him, I want to say that on two great grounds he is perfectly within his right in presenting this resolution. First, he is within his right if he believed in it; and secondly, I think probably it was his duty if asked by a member of this Society or a group of members to present it. Certainly, if I had been asked to present it, I would have done so.

Now, within the week, one of your officers was asked to attend a meeting of the Medical Advisory Committee of the Connecticut Birth Control League. Now, as published, I know most of the men who are on that Medical Advisory Committee. They are distinguished members of this Society, and I believe are sincere in their beliefs on this subject. This officer of this Society, with the approval of the President, attended this meeting, and at the meeting I am informed there were three members of the Medical Advisory Committee of the Connecticut Birth Control League, also members of this Society. At that meeting also was an attorney recently participating in the birth control court cases. Also at that meeting was an executive of a public relations firm from without the state, employed by the Connecticut Birth Control League to sponsor this suggested legislation. This bill that you are going to vote on will be called the bill of the Connecticut State Medical Society, your baby. This bill was written in longhand with pencil by the attorney recently participating in this court action. Subsequently, a field worker from this public relations committee appeared at the office of our Society to discuss this subject in its relation to the presentation before this House of Delegates and in addition, ways and means that might be suitably presented to the Legislature at its coming meeting.

Now, I think it behooves all of us, in view of the fact that this is a controversial subject, to be cautious in our speech and in the written word, to be temperate at all times. In the November issue of the Connecticut State Medical Journal this subject was rather thoroughly discussed and one phrase in there was in substance that medical advancement should take precedence over rejected and obsolete dogma. Well, perhaps that is so. If it is rejected and obsolete, it is still dogma. Dogma is a basic tenet of religion or doctrine. Regarding its obsolescence, my father had an overcoat that was called by some obsolete, but not by him. And one might ask, 'Rejected? — rejected by whom?' In order to reject anything one must first accept it.

I bring that out, not in criticism, but asking for caution and asking that we be temperate in the discussion of this subject.

In an effort to amicably adjust this subject, four members of the Council attempted to get a meeting of the Council together with the proponents of this legislation in order that it might be amicably adjusted. Unfortunately this was not successful.

This is the first time that I have discussed this subject publicly. It is the last time that I will discuss it here or anywhere else. Mine is a plea for harmony and for unity in this organization. If this House of Delegates passes this resolution today, your Secretary will be in duty bound to present that to the Legislature at its coming meeting.

Now, I can forsee when that takes place, if it does, all of the dangers that I have outlined for you, and I can foresee one other great danger that will be embarrassing to this Society. You have seen fit to elect as the President of this great Society a man who will be in office and if this legislation is passed today, I can foresee a sagacious newspaperman who will at once go to the Connecticut Birth Control League and ask them if they endorse the bill of the Connecticut State Medical Society, and of course the answer will be yes. I can foresee them going to him and asking him as the President of the Connecticut State Medical Society if he endorses that bill. Now, perhaps I have not the right to talk for him, but as I know him his answer will be, if you so vote today, that 'the House of Delegates has so ordered but I am personally opposed to this legislation'. Certainly if that takes place our situation will be an unfortunate one.

Now, may I suggest that if another group or another body of men wish to present such legislation, let those of us who are in favor of this legislation say so as individual members of this Society. Those who are opposed to it, if we wish, let us say that we are opposed to it. Mr. Chairman and gentlemen of the House of Delegates, I hope this resolution will be defeated and I am to vote against it.

President Linde: Any further discussion?

Dr. Stringfield: Mr. Chairman, this subject was discussed at our meeting of the County Society in Fairfield, at which time the opinion of our group was that we were not well enough informed on this subject at that time to vote upon it, and that we did not wish to vote upon this subject until it had been more thoroughly discussed among our own group, and it was tabled until next fall's meeting. Some of us discussed this matter and we felt that possibly it might be a wise plan if this subject were placed in the hands of the Public Health Committee or some other committee for a thorough study, and then their findings presented possibly to the Council. However, from the remarks of Dr. Murdock, I would feel the Council is well informed, but our Council is opposed at this time to this bill.

Dr. Gold: I think if this is passed in the House of Delegates, it will be a dangerous and unwise move.

President Linde: Any further discussion?

Dr. Landry: Mr. Chairman, inasmuch as Dr. Murdock has spoken relative to my ideas on the subject, I will have to say here that what he has said I certainly stand by. I recognize the fact that the House of Delegates, a democratic body, can bring to it any resolution for action. I, as President of the Medical Society, may be opposed to such a resolution and would have no hesitancy in informing the members of the Society. I might not express my feelings, and I certainly will not have a vote in the matter.

I would like to add to what Dr. Stringfield said that there is a feeling among many members that they have not been sufficiently informed about the nature of this bill. In fact, I would go so far as to say that there were very few members of the House of Delegates that were cognizant ot the fact that this bill was going to be brought up today. And I would say that the majority, if not all the remainder of the members of the Connecticut State Medical Society knew absolutely nothing of what was going to transpire here at the present time, and I think that the members here should vote 'No' on this resolution. I certainly will do that.

President Linde: Is there any further discussion?

Dr. Shepard: In all deference to the gentlemen who have spoken I would still like to say what I feel about this. I had no knowledge either that this proposal was going to be made today, but was personally delighted when I heard it. I feel and I have felt for years that doctors, individually and in scoieties, have been unduly cautious in even giving consideration to a very serious problem, that of birth control. I have felt hampered from following my own best judgment in certain cases. I feel that the health of the patient has been jeopardized because of that restriction. I feel as though this state were rather notorious in its attitude toward birth control. The state law, as you know, is practically as stringent as any in this country, and I have hoped for some years that the law would be changed, and I still hope so. I think that the doctors have been unduly cautious in expressing an opinion in this matter. I don't like to stir up a controversial matter or hurt peoples feelings, and I should be pleased to withdraw my motion if I had assurance that some definite stand would be taken on this — a resolution perhaps better couched or phrased more cautiously, but still a definite stand taken. I hope that the present law will be changed, I don't think anyone will be forced to go against the dictates of their own conscience if the law is changed. At the present time the seventy percent who are not basically opposed to this are under restrictions. I will withdraw my motion on the understanding that some definite stand be taken by the Society one way or the other. If the motion is made and fails, that will not prevent the Legislature at some future time from changing the law. It seems to me too bad that a matter of such importance medically should be decided by laymen and not by doctors themselves. I think the doctors could make a better resolution than a lay organization. And with the expectation that some equivalent action will be taken, I will withdraw my motion.

Dr. Harris: In deference to the importance of the question, and since it is agreed that this is a highly controversial one, and lest the Society's refusal to consider this matter at this time be considered as tacit denial on the part of the Society of the principles embodied in this motion, I think this subject, which is highly controversial, should be sent back to the constituent societies, either the county societies or the local societies, and that each of these societies instruct their delegates as to how they should vote this time. I think it much too important a question for us to decide as individual, uninstructed delegates, and I would therefore urge that this entire question be thrown back to the constituent societies which make up this Connecticut State Medical Society, and ask these constituent societies to direct their delegates as to how to vote on this very important question.

President Linde: Any further discussion?

Dr. F. H. Meyer: We can all remember the excuses people gave to us about where to get a pint of liquor, and the unscientific ways which prescriptions were written for that. The wording of this bill about mothers who are incapacitated due to health, etc., I can just imagine how that would be abused, and there again make the doctor almost a bootlegger or put him on an unscientific basis.

Dr. Blumer: I'd like to make a suggestion. I think I made it appear that I was the author of it. I can see very well where, if this Society passed the resolution as it now stands, it might put us in a very awkward position, and I wonder if it would help at all to modify that resolution to the effect that the Connecticut State Medical Society would support a bill covering the principles that I have expressed. Of course, what those principles amount to, assuming that all doctors are honest men, I have always thought were covered by our license to practice. I thought that when we were given a license, we were to do whatever was in the best interests of our patients. Certainly a woman who has obvious hypertension or something of that sort, if she comes into your office afraid that she is going to get pregnant again, I don't think any of you would stop from giving her advice on it, even if you wouldn't furnish contraceptives.

Dr. Parmalee: It seems to be the whole difficulty here is of entangling alliances. It is not my idea that the Connecticut State Medical Society should join hands with the Connecticut Birth Control League, but it does seem to me that the Connecticut State Medical Society might produce a resolution which would limit the use of contraceptives, for example, to private practices, hospital clinics and municipal clinics, and not have any connection with public clinics as we have had in the past.

Dr. Soltz: Mr. President, drugstores are still selling diaphrams and they are being used. I didn't know that this resolution was coming up this afternoon. I am not familiar enough with the workings of the House of Delegates to know whether the question of policy as to whether it is advisable to forget about birth control to save our face, or whether we ought to do something about it. But this much impresses me that if I do believe that medical men ought to continue to study birth control legislation, and if the majority of us believe in it, we certainly ought to go on record in some way, or at least make our best efforts to see that birth control is legally adopted rather than have it bootlegged through corner drugstores as it is being done today.

Now, if a physician doesn't believe in birth control, there is nothing that I understand from Dr. Blumer's resolution that would make him practice birth control. But on the other hand, as it now stands, those of us who believe in birth control — and I believe the majority of the medical men in this state believe in birth control — are not allowed to practice in it cases that we think there is a great urgent need for the practice of it. I certainly believe that the county medical societies ought to take the thing up as an earnest study, hear speakers on both sides, so that we may get well informed on the subject.

Speaking for the New London County Medical Society, we did go on record by a vote favoring birth control.

Dr. Linde: Any further discussion?

Acting as your presiding officer, and not attempting to interject any of my personal views on this matter, it seems to me that there are several recourses that you have if this motion is defeated, and it seems to me that the consensus of opinion, or the opinion of many of the men of the Society, is that these recourses may be taken. First, it may be sent out as a referendum to the various members of the Society. Second, it may be referred to the Public Health Committee, for their suggestions and referred back to either the Council, the House of Delegates, or a special meeting of the House of Delegates, or it might be referred to a special committee with the request to report at the House of Delegates — or it might be a special meeting of the House of Delegates before the Legislature convenes. It might be referred to the county societies for their discussion in their fall meetings. So that I think it is fair enough to say that the opponents of this bill seem to have that in mind, so that the thing will be thoroughly discussed before we jump into any difficulties. I do hope I haven't prejudiced anyone, and I hope that my remarks have been neutral.

Dr. Stringfield: Was the motion withdrawn as originally stated?

President Linde: It was withdrawn, but the second wasn't withdrawn.

Dr. Bird: I seconded that motion uninstructed. It is only my personal feeling in the matter that made me second the motion as it stood on the floor.

President Linde: The motion and the second have been withdrawn. I presume that leaves the slate clear as far as this motion is concerned. Is that right, Mr. Parliamentarian?

Dr. Landry: That's correct, sir.

Dr. Stringfield: Mr. Chairman, I'd like to make a motion that this matter be referred to the Public Health Committee with instructions that they thoroughly study it, refer it to the Council with their recommendations, and that the Council study it and refer it to the House of Delegates at possibly a special meeting in the fall.

President Linde: There will be a special meeting in the fall on the budget. Do I hear that seconded?

(The motion was seconded).

President Linde: It has been moved and seconded

(*Concluded on Page 548*)

SPECIAL NOTICES

PAN AMERICAN CONGRESS OF OPHTHALMOLOGY

Medicine will contribute to the growing cooperation of the Americas when the first Pan American Congress of Ophthalmology, bringing together a large group of eye specialists of the Western Hemisphere, meets in Cleveland, Ohio, October 11 and 12.

The American Academy of Ophthalmology and Otolaryngology, a society of more than 2,500 specialists of the United States, undertook sponsorship of the Pan American Congress as a means of promoting greater solidarity and wider acquaintance among medical men of the Americas. The need of such a gathering was emphasized by the postponement of the International Congress of Ophthalmology, which was to have met in Vienna in 1941, made necessary by the European conflict.

The first event of the Congress will be a joint banquet with the Academy Wednesday evening, October 9, at which Dr. Frank Brawley, Chicago, president of the Academy, will preside. Thursday afternoon, October 10, the official delegates appointed by the various governments will meet with representatives of ophthalmologic societies to draw up a constitution and make plans for future meetings.

Official recognition of the congress will be extended by the city of Cleveland at a reception Friday evening, October 11.

The scientific program will occupy two days, Friday and Saturday, October 11 and 12. Papers will be divided equally between speakers from the Latin American countries and those from the United States. Papers in Spanish or Portuguese will be discussed by English speaking physicians and those presented in English will be discussed by Latin American speakers. Slides showing a resume of each paper are to be shown on a screen in the two languages other than the one being spoken.

* * * *

AMERICAN BOARD OF OPHTHALMOLOGY

There will be only One Written Examination during 1941. This will be held in various cities throughout the country on March 8th.

Candidates enrolled in the Preparatory Group who have been advised that they will be eligible for examination during 1941 should make application AT ONCE to take this written examination.

Application must be made on the regular blanks provided for the purpose and must be received in the Board Office before December 1st, 1940.

Oral Examinations 1941	*Deadline for Case Reports*
Cleveland, May or June	February 1st
October (place to be announced later)	July 1st

A special oral and clinical examination will be held on the Pacific Coast during 1941 providing there will be enough candidates to warrant it. Applications for this examination should be filed before September 1st, 1940, so that the Board may complete necessary arrangements.

If you plan on taking your examination during 1941, please write at once to the Board Office for formal application blanks, indicating your preference of examination place.

AMERICAN BOARD OF OPHTHALMOLOGY
6830 Waterman Avenue
St. Louis, Missouri

* * * *

POSTGRADUATE COURSES AT N.Y.U. COLLEGE OF MEDICINE

Dean Currier McEwen of the New York University College of Medicine has announced the approval by Dr. Sigismund S. Goldwater, Commissioner of the Department of Hospitals of the City of New York, of postgraduate courses in internal medicine and in clinical electrocardiography, to be given on the wards of the Fourth Medical Division of Bellevue Hospital, under the sponsorship of the College.

The curriculum will emphasize modern methods of diagnosis and treatment as these courses are primarily intended for busy practitioners of medicine who wish to acquaint themselves with recent advances in these subjects. The plan of teaching is similar to courses previously given under the auspices of the Faculty of Medicine of Columbia University.

The course in internal medicine, under Dr. Charles H. Nammack, Director of the Fourth Medical Division, will last for one calendar month and will be repeated each month of the school year.

The course in electrocardiography, to be given over a fifteen week period, will be offered twice during the school year by Dr. Louis R. Bishop, Jr. The first session will begin on October 7, 1940. The work will cover the interpretation of the electrocardiogram and its practical application.

More detailed announcements and information will be furnished by the New York University College of Medicine.

* * * *

EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday January 4, 1941, at 2:00 P.M. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

The following action regarding case records to be submitted by candidates taking the Group B, Part I, examination after January 1, 1942, was passed by the Board at its annual meeting in Atlantic City, N.J., on June 6, 1940: "Case records submitted by candidates must be of patients treated within four years prior to the date of the candidates' application. The number of cases taken from one's residency service should not be more than half (25) of the total number of fifty (50) cases required."

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's Office not later than October 5, 1940.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, immediately prior to the June 1941 meeting of the American Medical Association.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6) Pennsylvania.

TRAINING REQUIREMENTS

In response to numerous inquiries regarding special training requirements, the Board desires again to announce that there are three methods of meeting these requirements for admission to the Board examinations. First by the residency system; second, by the partial residency and partial assistantship method; and third, entirely by the assistantship or "preceptorship" method. Details of the residency requirements are given in the Board booklet, sent by request.

The Board will accept in lieu of the formal residency service the training acquired by a candidate serving on an assistant or dispensary staff of an obstetrical and gynecological division of a recognized hospital, under the direction of a recognized obstetrician-gynecologist (preferably a Diplomate.) The time required for this type of training must be longer than with the formal, more intensive residency type of training, and the allowance of time depends upon the duties and responsibility given the candidate. Applicants lacking all formal special training should have a minimum of five years of hospital clinic, or assistant hospital staff appointments in the specialty, under approved direction. Teaching appointments without accompaning hospital staff or clinical appointments will not satisfy the Board requirements. A special form amplifying the original application must be filled out to cover the details of such assistantship, or preceptorship type, of training. The Board approves for special training, work done in institutions approved jointly by the Board and by the Council on Medical Education and Hospitals of the A.M.A.

• Abstract •

ALLANTOIN, A POSSIBLE LEUCOCYTOSIS PRODUCING FACTOR*†

Frederick R. Greenbaum, D.Sc.

Leucocytes are the white corpuscles of human blood. They differ from the red corpuscles (erythrocytes) in many particulars, such as being somewhat larger in size, in containing at least a single nucleus and possessing ameboid movements. The normal number of leucocytes in human blood varies between 5,000 to 10,000 per cubic millimeter. The ratio between the leucocytes and erythrocytes is about 1:350 to 1:500.

A leucocytosis is said to exist when the number of leucocytes is increased for any reason. As the white blood cells are "the policemen" in the blood stream and help combat infection, a leucocytosis is very often desirable in fighting an infectious disease.

Very often non-specific protein medication is given, such as intramuscular injection of milk or typhoid vaccine, which raises the white blood cells and thus counteracts the disease.

In 1912 Macalister had already observed that the injection of allantoin and also the oral administration of allantoin will produce an increase in leucocytes. He used it in pneumonia, with fair results. However, this discovery of Macalister went by unnoticed.

The introduction of allantoin in medicine in America, as one of the active ingredients of the excretion of maggots goes back to the rather recent work of William Robinson of the Bureau of Entomology, U. S. Department of Agriculture, who in 1935 demonstrated that the healing action of maggots is due to allantoin which they produce.

Our study concerned itself with the question if allantoin does or does not produce leucocytosis.

We established the fact that allantoin given intravenously, intramuscularly and orally to rabbits produces an increase in the leucocytes, particularly the neutrophiles. The neutrophiles are the important and healthy cells of the white blood cells.

It was found that intramuscular injection of 5 cc. of 0.4% allantoin solution shows a greater increase in the leucocytes than intravenous injection. Another point was clearly demonstrated that multiple intravenous or intramuscular injections do not yield as great an increase as single injections.

Allantoin given orally to rabbits produced a definite leucocytic response. Of course, this increase is not as distinct and as decisive as we have seen after the intravenous or intramuscular administration.

In dogs it was also found that intramuscular injection of allantoin produces a greater increase in the leucocytes than the intravenous injection. Orally, in dogs, allantoin produces a neutrophilic leucocytosis, provided a dose of 4.5 gm. of allantoin is given to each dog.

We have by way of rabbit and dog experiments established the fact that the intravenous and intramuscular injections of allantoin and the oral administration of allantoin produced a neutrophilic leucocytosis, thus confirming Macalister's work in 1912.

The fact that allantoin produces an increase in the white blood cells opens up the possibility that allantoin exerts its healing action due to a possible local leucocytosis, which sets in at the site of the wound or the osteomyelitis.

---

*Paper read at the American Chemical Society Meeting at Boston, Sept. 11-15, 1939.

†Abstract of paper which appeared in the Medical Record, April 17, 1940.

CAT.

HENRY LeBARON PETERS, M.D.
1882 — 1940

Doctor Henry LeBaron Peters died at his home in Bridgeport on August 2nd, from coronary thrombosis. He was active in his work up to five days previously, though his health had been impaired for some months.

Doctor Peters, or "Barry" as he was known throughout the State, was born in St. John, N.B. He received an A.B. degree from the University of New Brunswick in 1903 and his M.D. degree from McGill University in 1907. Following his graduation he served an internship at the Royal Victoria Hospitial in Montreal. From 1909 to 1912 he was at the City Hospital in New York, most of this time being spent in pathology with Professor Oertl. He also served as assistant pathologist at the Russell Sage Institute.

In 1912 Doctor Peters came to Bridgeport and established the department of Pathology and Bacteriology at the Bridgeport Hospital, and continued as its director till his death. The growth and present wide range of activity of this department is due entirely to his interest and untiring efforts.

In addition to his recognized ability as a pathologist, Doctor Peters was one of the ablest diagnosticians in the country. He had a clean cut way of going at a medical problem, and a fund of common sense that seemed to guide him in his decisions. For twenty years he served as attending physician at the Bridgeport Hospital, and also had the largest consulting practice in this vicinity. He was a member of the City, County, State and American Medical Associations, and a fellow of the American College of Physicians.

The tumor clinic at the Bridgeport Hospital was started under Doctor Peters' direction, and he continued as its guide and actual head. His advice and friendly counsel were always cheerfully given to any doctor seeking it, and he was always ready to give his time and best efforts on any puzzling ward case.

Absolutely honest himself in all things, it is doubtful if he ever suspected anyone else of being otherwise, and he welcomed any criticism of his management of a case. If someone asked his opinion he took him at his word and gave it. No doctor ever had more devoted patients and no patients ever had a doctor who gave more thought and study to their welfare than he did.

In 1916 Doctor Peters married Marguerite A. Bishop of Bridgeport. Mrs. Peters and two sons, Walker, a graduate of the University of Pennsylvania, and William, a Junior at University of Pennsylvania, survive him.

Doctor Peters will be greatly missed by his co-workers and a host of patients and friends.

D. C. P.

☆☆

PROCEEDINGS--HOUSE OF DELEGATES

(*Continued from Page 544*)

that this question be referred to the Public Health Committee for study, the Public Health Committee to report to the Council and the Council to report back to the special meeting of the House of Delegates to be held later in the year.

Is there any discussion on this motion?

(The motion was passed unanimously).

President Linde: It is a vote and so ordered.

The House of Delegates then adjourned until May 23, 1940, at the Hotel Bond.

• Quarto Notes •

SIMPLIFIED DIABETIC MANUAL

by

Abraham Rudy, M.D.

Associate Physician and Chief of the Diabetic Clinic, Beth Israel Hospital, Instructor in Medicine, Tufts College Medical School; Consultant in Diabetes, Jewish Memorial Hospital, Roxbury, Mass., and Jewish Tuberculosis Sanatorium, Rutland, Mass.

216 pages $2.00
New York M. Barrows & Co., Inc. 1940

This is an excellently written book, which would be of much value to a diabetic patient and those entrusted with their welfare and education. It is presented in a clear, practical manner and should aid the patient considerably in the task of controlling his disease. Diabetes, its causes, symptoms, complications and treatment, is discussed in detail, and the importance of its early recognition and treatment is emphasized. The role of heredity and other factors which might be a causation of diabetes are mentioned. Particular attention is also given to the complications of diabetes. The various problems which arise in treatment are discussed, especially those resulting from the use of protomine zinc insulin and crystalline insulin.

A considerable portion of this book is given over to diet — which is still the backbone of our treatment in diabetes. Here the necessity for well balanced diet is stressed, and the role which carbohydrates, proteins, fats, vitamins and mineral salts play is given due attention.

Numerous charts have been compiled to show the patient the value of different foods and the manner in which they might be substituted in the diet. Of interest, are the 163 recipes of various nationalities, which enables the patient to continue with the food habits of his race, without disturbing his prescribed diet. Throughout the book there are several illustrations and numerous tables, which are beneficial to the reader.

L. Fitton

* * * *

MODERN DIABETIC CARE

by

Herbert Pollack, A.B., Ph. D., M.D.

Instructor in Clinical Medicine, Cornell Medical College; Chief of the Diabetic Clinic, Mt. Sinai Hospital, New York

216 pages $2.00
New York Harcourt, Brace & Co. 1940

This is a good diabetic manual, written in a clear readable style, and made interesting even to a doctor. In fact in places it seems often to be written for the doctor through the medium of the patient as it tells what the doctor should do for the patient. As the average doctor takes altogether too little time for the diabetic, this is a good fault.

The first 70 pages are a simple, direct, interesting discussion of the normal and diabetic physiology — covering the physiology of heat production, the utilization of foods, and finally insulin. Then come 50 pages covering complications, coma, heredity, etc.

The last 70 pages of text are written by Dr. Pollack with Miss Marie W. Krause, the teaching dietitian at the New York Hospital. It is refreshing to see here re-emphasized that diabetics should use the regular family menu varied to their needs. Sample diets are given and also excellent tables of food equivalents with attention to food customs of various nationalities.

Dr. Pollack emphasizes the tendency to use protamine insulin more. Also he simplifies the laboratory controls stressing the variability of blood sugars and need of frequent urine tests while establishing controls. The rate of absorption of food is stressed more than usual — as using half or two-thirds of the days' protein at night to give a prolonged carbohydrate supply during the night. The main emphasis is on educating the diabetic well enough for hin to simplify his program safely.

B. J. Buck

* * * *

CLINICAL DIABETES MELLITUS AND HYPERINSULINISM

by

Russell M. Wilder, M.D. F.A.C.P.
Professor and Chief of the Department of Medicine, The Mayo Foundation

459 pages
Philadelphia W. B. Saunders C0. 1940

This book, by Russell M. Wilder, represents years of experience of an excellent clinician in the field of metabolism to which he has devoted most of his time. There have been associated with him many other medical men who are now filling places of the first rank, and he has drawn freely on his own experience and theirs in compiling this book. To the student of diabetes this book offers a great many interesting observations to add to his own experience, and the book is written in such a way that it is easy to differentiate fact from opinion. Text and foot-note references present all sides of each problem.

The arrangement is as a thoughtful clinician would have it in that the first chapter is devoted to the physiology of carbohydrate utilization in the body and the effect of the various organs on the blood sugar level. Then he passes to the definition of the pathological state called diabetes and emphasizes his belief in the unity of the disease "as an abnormality of metabolism created by an insufficiency of the insular activity of the pancreas." There follows detailed discussion of the diagnosis of diabetes as differentiated from the other melliturias.

The pathology of the disease is admitted as being unknown, there being no constant autopsy findings. Heredity has been credited as the most important factor as quoted from Joslin's Clinic. The predominance of the disease in the temperate zone gives interesting speculation as to climatological relationships. The fact is emphasized, however, that the pathological state is always corrected by the administration of insulin and can be produced by the complete destruction of the insular tissue. Then follow a number of correlated conditions which act as precipitating factors, the major ones of these being acute destructive lesions of the pancreas, obesity and hyperthyroidism.

Chapter 5 is very interesting in that it stresses the requirements for effective therapy in diabetes. Here Dr. Wilder emphasizes that the physician must have some knowledge of the subject, "more knowledge than many now possess." Second, he emphasizes that every general practitioner should have in his office facilities for measuring carbon dioxide combining power of the plasma and the concentration of the sugar in the blood. To the average practitioner this seems an impossible achievement. The third factor is careful instruction of the patient and a fourth is an understanding of the principles of general nutrition. The succeeding four chapters discuss in detail the use of insulin therapy, diabetic recipes and other procedures as camps for diabetic children, as established by Dr. Priscilla White in 1925, possible insulin substitutes, and supplementary vitamins and drugs. Most of Dr. Wilder's clinic patients receive protamine-zinc insulin and the large majority have supplementary doses of unmodified insulin. He emphasizes that insulin has ended the days of under-nutrition as such and all patients may now have adequate caloric intake of foods which are palatable. An excellent brief historical survey of diabetic diets is included before the detailed discussion of the present diet.

The next chapters deal with the abnormal states developing in diabetes and include a very specific account of diabetic acidosis and coma with excellent details for prevention and treatment of both. Here is discussed the perennial controversy as to the use of alkali which Dr. Wilder believes justified unless the response of the patient in the first few hours of treatment is very satisfactory. Dextrose is administered as soon as the need arises after the first two or three hours of treatment utilize that available in the body. The most striking factor of his outline of treatment is the constant care of minute details and it is to this that he accredits Joslin's excellent results.

In the chapter on "Infections Complicating Diabetes" he emphasizes the need for constant vigil and gives excellent details of the care including diet, insulin and fluids. Tuberculosis illustrates the value of these by a lowered mortality due to adequate nutrition.

Surgery for the diabetic also requires meticulous care, preoperative and postoperative. Where protamine insulin is used preoperatively it is continued postoperatively, being supplemented by a short acting insulin as needed. The danger of over dosing with insulin is emphasized and he believes "slight glycosuria will do little harm," and "the healing of surgical incisions is delayed when treatment of diabetes is inadequate — not otherwise."

In the section concerning genito-urinary complications the author brings out that the genital itching is usually caused by trichophytosis and will respond to no treatment except that of diabetes. The chapter on pregnancy and the care of the new born babe of the diabetic mother is most complete in detail as to treatment of both and may well serve as a reference for those who face this problem.

Ocular complications form a very informative chapter and the work of Waite and Beetham in Joslin's clinic is extensively quoted. Wrinkling of Descement's membrane is very common in diabetes, also transitory weakness of accommodation and refractive changes. These are due presumably to the rapid change in the diabetic under treatment. Dr. Wilder believes there is a characteristic retinal lesion of diabetes "with the appearance of tiny punctuate hemorrhages situated usually in the vicinity of dilated terminal vessels in the region of the macula. These hemorrhages are deep in the retina; therefore they are almost always round." This differs from the cotton-wool patches and hemorrhages seen in arteriosclerosis and no satisfactory treatment is known. The common variety of cataract is seen no more often in the diabetic than in the nondiabetic. There is, however, a true diabetic cataract, occurring among young people with severe diabetes. Fortunately this is rare. As to surgery in cataracts on diabetics, it is as any other surgery and "hyperglycemia and moderate glycosuria does not delay the healing of the iris and sclera."

Diabetic neuritis can cause not only pain and loss of reflexes but loss of muscle power and nerve degeneration. It is present today most in patients past 50 years of age and is very rare among the young who have received adequate treatment. Its severity is unrelated to the intensity of the diabetes or the dose of insulin required. The pathological lesions are in the nerve trunks and consist of patchy areas of degeneration with thickening of the walls of the nutrient vessels. It is emphasized that this complication is not fully understood.

Hemochromatosis is discussed as a cause of diabetes by an unknown metabolic disorder having principally to do with iron and causing diabetes by fibrosis of the pancreas. The diabetes is treated as any other diabetes and runs a variable course.

Arteriosclerosis is the same in the diabetic as in any other patient. The reaction of the diabetic to it is probably changed because of his general lack of resistance to infection. Also the "intensity of the sclerotic process and the occlusion of the arteries of the heart and legs are significantly greater in diabetics than they are among persons who are not diabetic." The cause of arteriosclerosis is still unknown.

Hyperinsulinism is discussed in the last four chapters of the book for the express purpose of bringing the subject to far greater attention and differentiating it from hypoglycemia of other origins. It is the opposite of diabetes and, though relieved somewhat by diet, can be cured only by removing the excessive supply of insulin. The diagnosis can be proven by operation or autopsy showing an adenoma or carcinoma in the island tissue of the pancreas. Only twelve cases have been proven in the Mayo clinic and these are presented.

B. J. Buck

* * * *

TOMORROW'S CHILDREN

Proceedings of the Southern Conference, November 9, 10 and 11, 1939, Atlanta, Georgia

170 pages Paper $0.75
New York Birth Control Federation of America, Inc. 1940

The Southern States lead all other States in illiteracy, they have the highest infant mortality and the highest maternal death rate in the United States as well as the worst health record in the nation. Doctor Woodbridge E. Morris, General Director of the Birth Control Federation of America, Inc., believes that either we shall go on providing for an ever growing population of the unfit who are replacing the fit of the nation, or we must adopt a nation-wide program of birth control.

The economic and social problems of the South are clearly portrayed in this volume which contains addresses by southern leaders in sociology, economics, social work and public health. Although the Conference at which these addresses were presented was sponsored by a birth control organization, there is much of informative value related only indirectly to birth control, to be gained from a careful reading of the volume. One could scarcely take exception to the suggestion of Professor Klaiss of the University of North Carolina that "it is the obligation of this generation to work out some solution to the economic muddle in which we find ourselves, in order that our children can live and marry in relative security." Parent education is sorely needed in the South as well as elsewhere throughout the United States. To quote Professor Klaiss again: "If parents can be taught to allow their children to grow up, to be emancipated, to be untied from the apron strings, it will be a great step. If parents can be made aware that they themselves are most responsible for their children's behavior perhaps improvement can be made and the next generation will have a better chance than we have had."

The population of the South is growing more rapidly by natural increase than that of any other region. Its excess of births over deaths is 10 per 1,000 as compared with the national average of 7 per 1,000. The typical Southerner is a poor man with many children. Poverty and fertility continue to go hand in hand, with the attending train of misery and bad health, poor housing, lack of education — the gamut which makes for an inferior stock. The State, according to George H. Cate, President of the Tennessee Conference of Social Work, has an obligation to tomorrow's children to see that every child is born into a home where he is wanted and where he will find affection and acceptance.

DRIP! DRIP! DRIP!

Doctors and surgeons everywhere are enthusiastic about the new "DryBrow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents each. (Extra utility: Some doctors use "DryBrow" golfing, others playing tennis). For sale at the Professional Equipment Company, New Haven.

(SEE ALSO PAGE 2)

ROSTER *of* MEMBERS

1940

FAIRFIELD COUNTY

President, Berkley M. Parmelee, 144 Golden Hill St., Bridgeport.
Vice-President, Ralph W. Crane, 50 Glenbrook Rd., Stamford
Secretary, J. Grady Booe, 144 Golden Hill St., Bridgeport
Treasurer, Clifton C. Taylor, 881 Lafayette St., Bridgeport.
Councilor, Samuel F. Mullins, 116 Main St., Danbury.

Censors

(One elected annually for a term of three years,)

J. Grady Booe, 144 Golden Hill St., Bridgeport.
Andrew M. McQueeney, 1315 Noble Ave., Bridgeport.
Berkley M. Parmelee, 144 Golden Hill St., Bridgeport.
William M. Stahl, 343 Main St., Danbury.
John H. Staub, 100 South St., Stamford.

Committee on Public Policy and Legislation

(Appointed annually by the President)

Luther C. Heidger, 972 East Broadway, Stratford.
Charles W. Knapp, 43 Maple Ave., Greenwich
Samuel F. Mullins, 116 Main St., Danbury

Committee on Medical Ethics and Deportment

(Two appointed annually by the President, for a term of four years,)

D. Chester Brown, 330 Main St., Danbury
Ralph W. Crane, 50 Glenbrook Rd., Stamford
James D. Gold, 839 Myrtle Ave., Bridgeport.
Henry K. W. Kellogg, 725 West Ave., Norwalk
Donald J. Knowlton, 36 Mason St., Greenwich
Andrew F. McGourty, 7 Glenbrook Rd., Stamford.
Berkley M. Parmelee, 144 Golden Hill St., Bridgeport.
Daniel C. Patterson, 881 Lafayette St., Bridgeport.
Henry C. Sherer, 1 Washington St., Norwalk.

Committe on Medical Economics

Stuart H. Bowman, 58 South St., Stamford.
David L. Ellrich, 125 East State St., Westport..
James D. Gold, 839 Myrtle Ave., Bridgeport..
Andras E. Laszlo, 881 Lafayette St., Bridgeport.
Morris P. Pitock, 570 Post Rd., Fairfield.
Oliver L. Stringfield, 1416 Bedford St., Stamford
William A. Sunderland, 158 Deer Hill Ave., Danbury.
Clifton C. Taylor, 881 Lafayette St., Bridgeport.
J. Leonard Vickers, 31 Hillside Drive, Greenwich.

Annual Meeting, Second Tuesday in April, at Bridgeport.

Semi-Annual Meeting, First Wednesday in October.

BETHEL

1940 Grigas, John E., 235 Greenwood ave.
1925 Moore, Homer Franklin, 4 Grand ave.
1938 Trimpert, Albert J., 155 Greenwood ave.
1939 Wolfson, Dexter, 58 Greenwich ave.

BRIDGEPORT

1933 Adzima, Joseph Matthew, 409 Noble ave.
1932 Alpert, Max, 881 Lafayette.
1935 Antell, Maxwell Joseph, 1690 Barnum ave.
1920 Apsel, Abraham, 1620 Fairfield ave.
1928 Backer, Marcus, 881 Lafayette.
1938 Bakunim, Maurice Irving, 654 Clinton ave.
1916 Banks, Daniel Tony, 385 Barnum ave.
1913 Beaudry, Joseph Horace, 109 Rowsley.
1913 Bernstein, Abraham, 472 State.
1900 Blank, Elmer Francis, 387 Noble ave.
1935 Bogin, Maxwell, 144 Golden Hill.
1921 Booe, John Grady, 144 Golden Hill.
1927 Brodsky, Michael Emanuel, 881 Lafayette.
1940 Brooks, Paul Lester, 1260 East Main.
1939 Buckhout, George Atherton, 2911 Fairfield ave.
1938 Buckley, John William, 2080 North ave.
1923 Buckmiller, Frank Charles, 1119 Stratford ave.
1919 Calvin, Claudius Virgil, 144 Golden Hill.
1920 Carroll, Francis Patrick, 919 Fairfield ave.
1932 Carroll, Philip Roger, Jr., 1131 Noble ave.
1940 Castaldo, Louis F. 47 Goodsell.
1920 Cheney, Maurice Lionel, 144 Golden Hill.
1925 Cohen, Joseph, 1130 Stratford ave.
1924 Conklin, Cornelius Stephen, 468 Clinton ave.
1936 Connors, Edwin Robert, 416 Boston ave.
1940 Coon, William Hall, R.F.D. No. 1
1935 Creaturo, Nicholas Edward, 1286 East Main.
1913 Curley, William Henry, 881 Lafayette.
1908 Curran, Philip John, 144 Golden Hill.
1894 Day, Fessenden Lorenzo, 819 Myrtle ave.
1920 DeLuca, Horatio Roger, 881 Lafayette.
1935 Del Vecchio, Leonard Frederick, 763 Noble ave.
1921 DeWitt, Edward Nicholas, 881 Lafayette.
1940 Dominick, DeWitt, 881 Lafayette.
1939 Edgar, Katherine J., 590 Brewster.
1937 Eimas, Aaron, 881 Lafayette.
1913 Finkelstone, Benjamin Brooks, 144 Golden Hill.
1897 Fleck, Harry Willard, 897 Lafayette.
1938 Foley, Francis Xavier, 2992 Main.
1908 Formichella, John B., 797 Washington ave.
1916 Gade, Carl Johannes, 144 Golden Hill.
1939 Gaffney, Charles Bernard, 850 Howard ave.
1929 Garbelnick, David Abraham, 1102 E. Main.
1907 Gardner, Charles Wesley, 144 Golden Hill.
1916 Garlick, George Burroughs, 144 Golden Hill.
1940 Geer, William Allyn, 881 Lafayette.
1916 Gilday, James Lowry, 819 State.
1927 Gildea, Mark Andrew, 881 Lafayette.
1895 Gold, James Douglas, 839 Myrtle ave.
1927 Greenspun, David Stoven, 144 Golden Hill.
1916 Griffin, Daniel Patrick, 1278 E. Main.
1923 Griswold, Arthur Sheldon, 144 Golden Hill.
1928 Griswold, Crawford, 144 Golden Hill.
1920 Groark, Owen James, 881 Lafayette.
1913 Hale, Fraray, 144 Golden Hill.
1939 Hardenburg, Daniel Bailey, 881 Lafayette.

1937 Harper, Paul, 144 Golden Hill.
1928 Harshbarger, Isaac Long, 144 Golden Hill.
1920 Havey, Leroy Austin, 144 Golden Hill.
1938 Hennessey, Joseph Gerard, 108 Rowsley.
1915 Hippolitus, Paul DiFrancesca, 255 Barnum ave.
1930 Hooper, G. Herbert, 1643 E. Main.
1933 Horn, Benjamin, 620 Clinton ave.
1916 Horn, Martin Irving, 915 North ave.
1920 Howard, Joseph Henry, 144 Golden Hill.
1938 Hurlburt, Edward Glens, 610 Laurel ave.
1912 Hyde, Charles Elias, 881 Lafayette.
1932 James, Arthur Gregory Boswell, 1424 Stratford ave.
1932 Kalman, Eugene, 1389 Fairfield ave.
1927 Keegan, Daniel Francis, 144 Golden Hill.
1938 Keys, Robert C., 881 Lafayette.
1924 Kneale Halford Benson, 144 Golden Hill.
1924 Kornblut, Alfred, 1539 Fairfield ave.
1913 Lambert, Henry Bertram, 144 Golden Hill.
1926 Laszlo, Andras E., 881 Lafayette.
1940 Lengyel, Paul, 787 Hancock ave.
1925 Levenson, Albert, 881 Lafayette.
1904 Leverty, Charles Joseph, 528 Park pl.
1933 Levinsky, Maurice, 480 Noble ave.
1927 Levy, Maurice Noel, 480 Clinton ave.
1940 Little, Olga A.G. 1278 East Main.
1931 Lockhart, Reuben Harold, 144 Golden Hill.
1887 Lynch, John Charles, 826 Myrtle ave.
1904 Lynch, Robert Joseph, 144 Golden Hill.
1932 Margulis, Ben, 171 Harrison.
1922 Maxwell, John Alphonsus, 919 Stratford ave.
1923 McManus, James Patrick, 1390 E. Main.
1913 McQueeney, Andrew Michael, 1315 Noble ave.
1931 Meyer, Fritz Martin, 144 Golden Hill.
1892 Miles, Henry Shillingford, 144 Golden Hill.
1940 Monahan, David Tuite, 144 Golden Hill
1932 Mooney, Sydney, 1116 Stratford ave.
1936 Murray, William J. C., 784 Noble ave.
1938 Nespeco, James V., 2546 Main.
1901 Nettleton, Irving La Field, 775 Washington ave.
1919 Neumann, Harry Aaron, 588 State.
1937 Newton, Louis, 881 Lafayette
1925 Nichols, Charles William, 1221 Stratford ave.
1920 Nichum, John Stanley, 144 Golden Hill.
1936 Nolan, John Francis, 1260 E. Main.
1925 O'Brien, Francis James, 74 Circular ave.
1940 Panettieri, Andrew Joseph, 3084 Main.
1921 Parmelee, Berkley Melvin, 144 Golden Hill.
1937 Pascal, Thomas J., 385 Noble ave.
1909 Patterson, Daniel Cleveland 881 Lafayette.
1913 Peters, Henry LeBaron, 763 Park ave.
1930 Pileggi, Peter, 743 Washington ave.
1935 Plukas, Joseph Martin, 339 South ave.
1933 Quatrano, Joseph Charles, 835 Fairfield ave.
1916 Quinn, John Francis, 144 Golden Hill.
1916 Reich, Upton Sharetts, 2095 Main.
1938 Ribner, Harold, 881 Lafayette.
1918 Roberts, Edward Russell, 144 Golden Hill.
1913 Roche, Thomas Joseph, 1815 Noble ave.
1936 Rockwell, Alice Elizabeth, 1775 Noble ave.
1928 Sekerak, Arthur Joseph, 938 E. Main.
1938 Sekerak, Raymond Andrew, 1458 E. Main.
1938 Sekerak, Richard John, 938 E. Main.
1938 Shea, Cornelius Joseph, 1153 Park ave.
1913 Shea, John Francis, 144 Golden Hill.
1937 Shea, Richard O'Brien, Welfare Building.
1939 Simses, John Peter, 651 State.
1903 Smith, Edward Dorland, 881 Lafayette.
1935 Smith, Joseph Jacob, 1280 Stratfield rd.
1919 Smith, Stanton Reinhart, 144 Golden Hill.
1913 Smykowski, Bronislaw Louis, 405 Barnum ave.
1930 Sollosy, Alexander, 645 Bostwick ave.
1909 Sprague, Charles Harry, 29 Hanover.
1940 Tarasovic, Thomas Joseph, 49 Dover.
1920 Taylor, Clifton Clark, 881 Lafayette.
1938 Ter Kuile, Roger Couvelle, 881 Lafayette.
1925 Tolk, Nathan Robert, 558 Clinton ave.
1895 Tukey, Frank Martin, 144 Golden Hill.
1929 Turchik, Frank, 1831 Barnum ave.
1932 Uvitsky, Irving Harry, 3101 Main.
1923 Walsh, James Francis, 583 Noble ave.
1903 Warner, George Howell, 144 Golden Hill.
1920 Watts, Joseph Francis, 881 Lafayette.
1913 Weadon, William Lee, 144 Golden Hill.
1934 Wehger, Roland Theodore, 144 Golden Hill.
1922 Weise, Ellwood Carl, 144 Golden Hill.
1914 Weldon, Edwin Bernard, 144 Golden Hill.
1936 Yeager, Charles Frederick, 2139 E. Main.
1935 Zaur, Israel Sidney, 881 Lafayette

BROOKFIELD CENTER

1939 Brewer, Francis.

DANBURY

1929 Amos, Isadore Louis, 317 Main.
1929 Booth, John Dibble, 173 Main.
1902 Bronson William Thaddeus, 41 West.
1888 Brown, David Chester, 330 Main.
1928 Delohery, Cornelius Leo, 215 Main.
1935 Driscoll, Jerome James, 206 Main.
1937 Eckert, George Robert, 394 Main.
1931 Gaffney, John James, 179 Main.
1931 Genovese, Frank Thomas, 172 White.
1938 Genovese, Serafino, 390 Main.
1930 Gibson, Donald Farnham, 75 West.
1929 Goldys, Frank Max, 209 Main.
1897 Gordon, William Francis, 26 West.
1912 Moore, Howard Delano, 203 Main.
1912 Mullins, Samuel Frederick, 116 Main.
1937 Murphy, James Joseph, 147 Main.
1939 Murray, Thomas O. 145 Deer Hill ave.
1937 Rogol, Louis, 229 Main.
1926 Selleck, Nathaniel Benedict, 215 Main.
1913 Smith, Arthur Charles, 246 Main.
1920 Stahl, William Martin, 343 Main.
1907 Sunderland, Paul Ulysses, 160 Deer Hill ave.
1929 Sunderland, William Alexander, 158 Deer Hill ave.
1932 Tomaino, Felix Francis, 8 West.

DARIEN

1937 Huntington, Frederic Sargent, Middlesex and Hollow Tree Ridge Roads.
1940 Ross, Allan Maxwell, 188 Post rd.
1938 Van Tassel, Walter, 194 Post rd.

FAIRFIELD

1939 Biehn, Donald M. Frick, 133 Reef rd.
1928 Biehn, Sidney Lister, 22 Reef rd.
1938 Fulstow, Marjorie, 1248 Post rd.

1940 Little, Mervyn Henry, 50 Reef rd.
1932 Pitock, Morris Philip, 570 Post rd.

SOUTHPORT

1938 Mathews, Frank Pelletreau, Main.

GREENWICH

1935 Amoss, Harold Lindsey, 21 Field Point rd.
1938 Carter, Gray, 29 Hillside ave.
1934 Clark, J. Bayard, 18 Field Point rd.
1904 Clarke, John Alexander, 92 Mason.
1933 Close, John Frederick, 66 Milbank ave.
1937 Craighill, Margaret D., 40 West Elm st.
1937 Gates, Aaron Billings, 305 Millbank ave.
1937 Hawthorne, Julian, Greenwich Towers.
1934 Hitchcock, Freeman St. Clair, 275 N. Maple ave.
1927 Knapp, Charles Stanley, 18 Field Point rd.
1918 Knapp, Charles Whittemore, 43 Maple ave.
1916 Knowlton, Donald Jerome, 36 Mason.
1940 Larimore, Louise D., Greenwich Hospital.
1933 Lockwood, Jane, 271 Lake ave.
1932 *McCreery, John Alexander, 43 Maple ave.
1939 Reynolds, Whitman Mead, 53 Mason st.
1935 Rogers, Robert Page, 111 North.
1938 Serrell, Howard P., 43 Maple ave.
1940 Shaw, Lillian Eloise, Ituri Towers.
1937 Strobel, Joseph E., 34 Benedict pl.
1937 Thompson, Sidney Attilio, 161 Mason.
1934 Tinkess, Donald Ewing, Ituri Towers.
1939 Tunick, George L., 193 Mason.
1933 Vickers, James Leonard, 40 West Elm.

Cos Cob

1940 Ayres, Payson Bryan, 10 Old Post rd.
1912 Bergin, Thomas Joseph, 2 Mead ave.

Old Greenwich

1914 Austin, Albert Elmer, 13 Arcadia rd.
1926 Kaprielian, Haigazoon Kruger, 312 Sound Beach ave.
1936 Kelly, James Colman Francis, 282 Sound Beach ave.
1939 Read, Francis Arnold, 127 Sound Beach ave.
1929 Shermak, Joseph V., 13 Arcadia rd.

MONROE

Stepney Depot

1912 Wales, Francis Joseph.

NEW CANAAN

1937 Abrahams, Meyer, 191 South.
1933 Bucciarelli, John Anthony, 93 East ave.
1939 Cammann, Oswald DeN., 80 South ave.
1938 DuBois, Franklin Smith, Silver Hill.
1939 Frothingham, John Gerrish, 149 South Main st.
1932 *Lowsley, Oswald Swinney, "Twin Knolls" 29 Cherry
1935 Ludlow, George Craig, 8 Oendie ave.
1939 McIlroy, Patrick Thomas, 25 Church st.
1908 O'Shaughnessy, Edmund Joseph, 29 Cherry.
1938 Selenger, Jerome, Elm st.
1935 Terhune, William Barclay, Silver Hill.
1931 Wadsworth, Ruth Flanigen, Smith Ridge.

NEWTOWN

1938 Dean, Stanley Rochelle, Fairfield State Hospital.
1927 Desmond, Waldo Fairfield, Main St.
1935 Grout, Stillman Proctor, Fairfield State Hospital.
1936 Moore, Clifford Douglas, Fairfield State Hospital.

Sandy Hook

1937 Egee, J. Benton.

NORWALK

1933 Chipman, Sidney Shaw, 520 West ave.
1940 Fitzpatrick, Wesley Fenton, 85 East ave.
1938 Gorham, Grace Viola, 64 Wall.
1915 Kellogg, Henry Kirke White, 725 West ave.
1930 Miller, John, 711 West ave., and 65 North St., Greenwich
1938 Northrop, Robert Arthur, 64 Wall.
1938 Padula. Ralph Domenick, 502 West ave.
1929 Patterson, Frederic Arthur, 520 West ave.
1938 Perdue, Robert E., 625 West ave.
1930 Perkins, Charles Winfield, 520 West ave.
1920 Perry, Mabelle Jeane, 676 West ave.
1938 Piasecki, Joseph L., 520 West ave.
1928 Scanlon, Thomas Francis, 394 West ave.
1934 Stone, William Stephen, Chestnut Hill.
1929 Tracey, Edward John, 637 West ave.
1890 Tracey, William Joseph, 637 West ave.
1920 Tracey, William Wallace, 637 West ave.
1904 Turner, Arthur Robert, 701 West ave.
1938 Vollmer, John William, 654 West ave.
1934 Wallace, Victor George Henry, 643 West ave., and 1 Atlantic st., Stamford.
1938 Weinstein, Nathan, 463 West ave.

South Norwalk

1936 Beck, Eugene Cornelius, 75 So. Main.
1918 Bradley, Theron Robert, 9 Washington.
1938 Corridon, James Donald, 47 Seaview ave.
1922 Fawcett, George Gifford, 8 Washington.
1938 Giuliano, Louis Augustine, 111 West ave.
1940 Heafey, John R., 3 Washington.
1938 Hunkemeir, Edna, 75 So. Main.
1923 McMahon, William Henry, Jr., 13 Washington.
1938 Paris, Marcus, 64 So. Main.
1938 Rosenthal, Isidor, 72 So. Main.
1939 Scanlon, John Joseph, 230 West ave.
1939 Shain, Joseph H., 76 South Main.
1896 Sherer, Henry Clifford, 1 Washington.
1931 Simon, Louis Goodwin, 59 South Main.
1937 Stietzel, Eric Ernst, 19 Franklin.
1939 Zweben, Albert, 74 South Main.

RIDGEFIELD

1937 Bell, Joseph Sloane, 54 Main.
1926 Lowe, Russell Walter, 126 Main.
1927 Woodford, Francis Bowditch, 62 Main.

SHELTON

1939 Edson, Ralph Howard, 77 Oak ave.
1917 Finn, Edward James, 452 Howe ave.
1930 Gaetz, Thomas Harold, "Laurel Heights."
1937 Howlett, Kirby Smith Jr., "Laurel Heights."
1925 Lynch, Edward James, "Laurel Heights."
1895 Randall, William Sherman, 241 Coram ave.
1938 Rilance, Arnold Boor, "Laurel Heights."

STAMFORD

1937 Awdziewicz, Francis J., 295 Atlantic.
1936 Bannon, Frederick Michael, 65 South.
1907 Barnes, Frank Haslehurst, Dr. Barnes, Sanitarium.
1927 Bissell, Addison Hayes, 65 South.
1926 Bowman, Stuart Howard, 58 South.
1940 Bria, William F., 25 Bedford.
1928 Brown, Paul Hemingway, 52 South.
1935 Carpenter, Robert Morse, 636 Sumner.

1937 Carwin, Joseph Lucian, Jr., 115 West Main.
1940 Cognetta, James J., 366 Atlantic.
1937 Costanzo, James Joseph, 58 South.
1928 Costanzo, Ralph Edward, 18 Broad.
1909 Crane, Ralph William, 50 Glenbrook rd.
1937 Cunningham, Robert D. M., 1 Atlantic.
1934 D'Andrea, Frank Henry, 29 South.
1909 Ditchter, Charles Levi, 33 Forest.
1935 Dichter, Irving Samuel, 65 Broad st.
1937 Di Francesco, Lindo Peter, 29 South.
1937 Dorion, Robinson Harry, 449 Atlantic.
1933 Fincke, Charles Louis, 1 Atlantic.
1937 Fine, Barnet, 49 Grove.
1936 Fine, Joseph, 96 Main.
1931 Fiske, Madeline, 29 Suburban ave.
1934 Friedberg, Solomon, 21 Forest.
1931 Gandy, Raymond Alfred, 57 Broad.
1913 Gandy, Raymond Reeves, 57 Broad.
1931 Giles, Newell Walton, 1 Atlantic.
1909 Godfrey, William Truitt, 65 South.
1938 Grant, A. Nathaniel, 115 West Main.
1929 Hamilton, John Stewart Marshall, 88 South.
1937 Harrison, Francis Murphy, 512 Atlantic.
1908 Harrison, John Francis, 512 Atlantic.
1916 Henderson, Alfred Collard, 55 Glenbrook rd.
1935 Henderson, Jean, 55 Glenbrook rd.
1901 Hertzberg, George Robert Reinhold, 40 South.
1930 Hertzberg, Reinhold Frederick, 227 Bedford.
1937 Hopper, Edward Bernard, 58 South.
1937 Hymovich, Leo, 74 Park pl.
1929 Keddy, Russell Alfred, Stamford Hospital.
1938 Kezel, Albert Patrick C., 23 Atlantic.
1904 MacLean, Donald Robert, 31 West Park pl.
1934 Malloy, Edward Francis, 65 South.
1933 McFarland, Frederick William, 65 South.
1928 McGourty, Andrew Frederick, 7 Glenbrook rd.
1935 McGourty, David Philip, 25 Bedford.
1924 McMahon, Francis Cash, 62 Suburban ave.
1934 Meade, Charles Havelock Beverly, 433 Atlantic.
1930 Meschter, Eugene Funk, Yale & Towne Co.
1938 Murphy, Charles Anthony, 65 South.
1931 Murray, Henry Joseph, 53 South.
1940 Nemoitin, Bernard Oscar, 96 Main
1911 Nemoitin, Jacob, 96 Main.
1928 Paul, Voyle Abrams, 58 South.
1938 Rawls, Edward Cotton, 1 Atlantic.
1929 Resnik, William Harry, 65 South.
1928 Root, Stella Quimby, 39 Broad.
1936 Rose, Samuel A., 25 Bedford.
1937 Rowell, E. Everett, 104 South.
1929 Rynard, William Morvel Wesley, 29 South.
1932 *Schmidt, Norman Louis, 58 South.
1930 Sette, Alfred Joseph, 308 Atlantic.
1938 Sherman, Saul H., 81 Bedford st.
1909 Shirk, Samuel Martin, 218 Bedford.
1936 Shockley, Francis Milton, Stamford Hall.
1917 Smith, William Earl, 65 South.
1934 Starrett, Jay Ellis, 885 Summer.
1907 Staub, John Howard, 100 South.
1931 Stone, Merlin Jones, 76 Glenbrook rd. Also 161 Mason, Greenwich.
1920 Stringfield, Oliver Linwood, 1416 Bedford st.
1937 Throckmorton, Verl John, Stamford Trust Bldg.
1940 Troy, William D. 3 St. George ave.
1931 Turnley, William Henry, 1 Atlantic st.
1934 Turton, Effie Howe, 90 Prospect.
1939 Washburn, Wendell James, 65 South and 261 Lake ave., Greenwich.
1937 Weaver, Bruce S., 77 South.
1928 White, William Beverly, 322 Main.
1930 Wilson, Leo Earl, 87 South.

Glenbrook

1938 O'Meara, Francis Patrick, 1 Elm pl.
1885 Phillips, Alfred Noroton, Middlesex rd.

SPRINGDALE

1937 Diamond, Edward H., 990 Hope.

STRATFORD

1938 Ashcroft, Allan Davis, 3585 Main
1938 Findorak, Francis George, 1882 Barnum ave.
1936 Friedman, Nathan H., 891 E. Broadway.
1927 Haberlin, Chester Edward, 2921 Main.
1924 Heidger, Luther Caldwell, 972 E. Broadway.
1929 Hennessey, Edward Henry Joseph, 2390 Main.
1939 Levy, Samuel Howard, 2528 Main.
1934 Maher, John Rodden, 2184 Main,
1931 Oesau, Harold Thomas, 1949 Main.
1940 Penner, Sidney Lincoln, 2692 Main.
1937 Strayer, Estella M., 3486 Main.
1935 Strayer, Luther Milton, Jr., 3486 Main.

TRUMBULL

Long Hill

1912 Smith, George Arthur.

WESTPORT

1904 Bill, Philip Worcester, 40 Thomas rd.
1930 Ellrich, David Lionel, 125 E. State.
1932 Gillette, Claude Wesley, 110 Charles.
1937 Lynch, Hubbard, Evergreen ave.
1934 Morgan, William Oliver, 193 Main.
1927 Munson, William Russell, 20 Church lane.
1937 Nespor, Robert Venzel, 89 Main.
1925 Phillips, Harry Shaw, 44 E. Church.
1936 Teuscher, William P., 18 Compo rd.

Greens Farms

1934 Smith, Stephen Munro, Box 31.

WILTON

1939 Knauth, Marjorie S., Drum Hill rd.

OUT OF COUNTY

1939 Esposito, Joseph John, Welfare Hosp., New York City.
1939 Ireland, Richard Milton, 66 Bridge st., New Milford.
1939 Keating, John Joseph, 20 So. Main st., New Milford.
1939 Lynn, John Gallaway, 735 West 172th st., N.Y.C.
1933 Maddren, William Harvey, 126 Pine st., Freeport, L. I.
1907 Pratt, Nathan Tolles. Old Saybrook.
1937 Millet, John Alfred Parson, 770 Park ave., N.Y.C.
1929 Salmond, Paul H., Box 39, North Battleford, Saskatchewan, Canada.
1939 Smith, George Yale, 6802 Ridge Boulevard, Brooklyn, N.Y.

Total number 379

HARTFORD COUNTY

President, William T. Morrissey, M.D., 55 W. Main Street, New Britain.

Vice-President, Thatcher W. Worthen, M.D., 179 Allyn Street, Hartford.

Secretary, Frank T. Oberg. M.D., 689 Asylum Avenue, Hartford.

Councilor, Edward J. Whalen, M.D., 750 Main Street, Hartford.

Business Office, 38 Prospect Street, Hartford.

Censors

(One elected annually for a term of three years)

George A. Gosselin, M.D., 50 Farmington ave., Hartford
Maurice T. Root, M.D., 51 North Main Street, West Hartford.
Benedict N. Whipple, M.D., 45 N. Main Street, Bristol.
George A. Gosselin, M.D., 50 Farmington ave., Hartford

Committee on Public Policy and Legislation

(State Committee member and one elected annually for a term of two years)

1941 D.C.Y. Moore, M.D., 689 Main Street, So. Manchester.
1942 Fred C. Erlander, M.D., 25 Arch Street, New Britain.

Committee on Medical Ethics and Deportment

(Two appointed annually by the President for a term of three years)

1941 William F. Flanagan, M.D., 55 West Main Street, New Britain.
1941 C. Brewster Brainard, M.D., 50 Farmington Avenue, Hartford.
1942 William R. Hanrahan, M.D., 147 Main Street Bristol.
1942 Richard E. Dunne, M.D., 30 Farmington Avenue. Hartford.
1943 Freeman D. Clason, 179 Allyn Street, Hartford.
1943 Lawrence H. Frost, 98 W. Main Street, Plainville.
The President of the County Medical Association.
The Secretary of the County Medical Association.

Annual Meeting, First Tuesday in April.
Semi-Annual Meeting, Fourth Tuesday in October

BERLIN

1908 Hodgson, Thomas Cady, Worthington Ridge.

Kensington

1938 Lo Vetere, Angelo Arthur, 528 Farmington.

BLOOMFIELD

1936 Burgdorf, Alfred Louis, Duncaster rd.

BRISTOL

1930 Appell, Paul Harry, 227 Main.
1934 Beatrice, Alphonse Anthony, 331 Main.
1936 Bird, Frederick, Stanford, 9 N. Main.
1932 Borkowski, Boleslaus Joseph, 4 School.
1900 Brackett, Arthur Stone, 321 Main.
1934 Donohue, Bartholomew Francis, 481 N. Main.
1935 Flynn, William Henry, 9 N. Main.
1925 Gore, Michael Alvord, 321 Main.
1937 Hall, Martin Irving, 269 N. Main.
1921 Hanrahan, William Richard, 157 Main.
1938 Hudon, Frederick Alfred, 321 Main.
1939 Labuz, Eugene Frank, 342 Main.
1928 LaPlume, Albert Antonio, 218 West.
1939 Martin, Oliver Lilbourn, Bristol Hospital.
1929 Nestos, Peter Alexander, 63 Main.
1935 Papa, John Smith, 124 Main.
1921 Park, Paul Archibald, 133 Main.
1921 Richardson, Ralph Augustus, 4 School.
1922 Robbins, Benjamim Bissell, 47 Main.
1935 Siliciano, Raoul Andrew Victorius, 110 South.
1936 Stevenson, William Robb, 7 Prospect.
1939 Tirella, Fred Francis, 481 N. Main.
1909 Whipple, Benedict Nolasco, 45 N. Main.
1934 Winters, Herman W., 405 N. Main.

CANTON

Collinsville

1906 Cox, Ralph Benjamin.

EAST HARTFORD

1931 Brecker, Francis Wellington, 9 Burnside ave.
1937 Cornwell, Philip M., 970 Main.
1936 Gallivan, John Norman, 74 Connecticut blvd.
1927 Goddard, Harvey Burton, 970 Main.
1923 Haylett, Howard Bulkeley, 1109 Main.
1933 Houle, Raymond Theodore, 1010 Main.
1934 Lublin, Raymond David, 759 Main.
1937 McCue, Martin Patrick, 1429 Main.
1939 Mirabile, Thomas Joseph, 7 Woodridge ave.
1916 Onderdonk, Harrie Jay, 61 Richard rd.

EAST WINDSOR

Broad Brook

1923 Robinson, Wilfred John Thomas, Main.
1937 Maslak, Rudolph, South Main, Warehouse Point.

ENFIELD

Hazardville

1906 Bridge, John Law, P.O. Box 272.
1923 Shepard, William Gordon, Main.

Thompsonville

1937 Bloom, David Irving, 134 Pearl.
1937 Dignam, Barnard Stephen, 59 Pearl.
1906 Dowd, Michael Joseph, 25 Church.
1932 Fancher, Henry Wilson, 1070 Enfield.
1938 Gourlie, Howard Wallace, 53 New King st.
1932 McHugh, John Francis, 29 Central.
1916 Simonton, Frank Forester, 75 N. Main.
1928 Stein, Albert, 144 Pearl.
1917 Vail, Thornton Edwin, 124 Main.

FARMINGTON

1933 Bunnell, Walls Willard, Main.
1933 Ellis, Francis Duffy, Jr., Elm Tree Inn.
1939 Ewell, John Woodruff, Farmington

GLASTONBURY

1933 Earle, Benjamin Baylis, 2458 Main.
1935 Griswold, Edwin Monroe, 28 Ripley rd.
1939 Raffa, Joseph, 2638 Main.
1924 Whittles, Lee Jay, 2205 Main.

South Glastonbury

1908 Ward, James Ward, 972 Main.

GRANBY

1923 Pendleton, Ernest Raymond.

North Granby

1919 Stockwell, William M. Stockade

HARTFORD

1927 Allen, Wilmar Mason, 20 S. Hudson.
1937 Andrews, Egbert Merill, 648 Asylum.
1935 Angus, Leslie Robert, 200 Retreat ave.
1927 Antupit, Louis, 242 Trumbull

1936 Apter, Harry, 1453 Main.
1932 Arons, Milton Robert, 1061 Albany ave.
1904 Backus, Harold Simeon, 99 Pratt.
1934 Bailey, Harry, 242 Trumbull.
1913 Bailey, Neil Herbert, 550 Main.
1923 Bancroft, Harold Arthur, 179 Allyn.
1940 Barker, Norman J. 55 Elm.
1933 Bausch, Carl Philipp, 36 Pearl.
1886 Beach, Charles Coffing, 54 Woodland.
1907 Beach, Charles Thomas, 50 Farmington ave.
1929 Beatman, Israel, 650 Main.
1934 Beizer, Edmund, 1711 Park.
1923 Bestor, Eugene Leonard, 36 Pearl.
1926 Bidgood, Charles Young, 179 Allyn.
1936 Bingham, Charles Tiffany, 751 Asylum ave.
1913 Biram, James Harrington, 179 Allyn.
1913 Birdsong, Julian Lee, 435 Farmington ave.
1938 Birge, Henry L., 179 Allyn.
1907 Blair, Edward Holden, 43 Farmington ave.
1897 Botsford, Charles Porter, 219 Collins.
1903 Brainard, Clifford Brewster, 50 Farmington ave.
1916 Branon, Anthony William, 179 Allyn.
1912 Brayton, Howard Wheaton, 179 Allyn
1939 Brennan, Edward L., 200 Retreat ave.
1931 Brewer, Timothy Francis, 211 Church.
1929 Buck, Burdette Jay, 50 Farmington ave.
1931 Buckley, Richard Cotter, 683 Asylum ave.
1932 Burlingame, Clarence Charles, 200 Retreat ave.
1937 Burns, Maudie Marie, State Office building.
1928 Butler, Nicholas George, 50 Farmington ave.
1930 Byrne, David Walter, 179 Allyn.
1931 Calverley, Eleanor Jane Taylor, 143 Sigourney.
1914 Cantarow, Daniel, 10 Garden.
1934 Cappiello, Silvestro, 97 Vine.
1933 Carey, Thomas Cornelius, 50 Farmington ave.
1931 Carniglia, Ettore Francis, 50 Farmington ave.
1929 Carroll, James Edward, 220 Farmington ave.
1915 Carter, Earle Buell, 99 Pratt.
1930 Caulfield, Ernest Joseph, 683 Asylum ave.
1933 Cenci, Vincent Peter, 242 Trumbull.
1935 Clarke, Ralph deBallard, "Cedarcrest."
1922 Clason, Freeman Pell, 179 Allyn.
1937 Clifford, Martha Louise, 165 Capitol ave.
1905 Clifton, Harry Colman, 30 Farmington ave.
1931 Climan, Max, 242 Trumbull.
1896 Cochran, Levi Bennett, 50 Farmington ave.
1928 Cogan, George Eugene, 50 Farmington ave.
1940 Cogland, John Lee, "Cedarcrest."
1913 Cogswell, Eliot Sanborn, 179 Allyn.
1936 Cogswell, Lawrence Perley, 50 Farmington ave.
1938 Cohn, Samuel Hills, 715 Asylum.
1935 Connor, Joseph Joyce, 750 Main.
1933 Corcoran, Michael Anthony, 41 Webster.
1913 Costello, Henry Nicholas, 134 Beacon.
1924 Couch, Arthur Rockwell, 95 Farmington ave.
1921 Cragin, Donald Brett, 151 Farmington ave.
1933 Crosby, Edward Harding, 50 Farmington ave.
1936 Cunningham, James Morrow, 165 Capitol ave.
1914 Daly, Charles William, 750 Main.
1935 Daly, William Patrick, 342 Edgewood.
1929 Davenport, Anna Keith Prentiss, 54 Church.
1932 Dawson, Lionel Montrose, 700 Main.
1909 DeBonis, Domencio, A., 183 Westland.
1914 Deming, Clinton Demas, 179 Allyn.
1914 Deming, Edward Adams, 715 Asylum ave.
1931 DePasquale, Francis Lawrence, 1026 Main.
1937 DePasquale, John Anthony, 525 Main.
1934 DeVito, Michael Joseph, 1039 Main.
1930 Dignam, Edward Anthony, 750 Main.
1921 Dinsmore, William Wirt, 700 Main.
1931 Dion, Asa Joseph, 207 Washington.
1939 Dodd, Burwell, 689 Asylum.
1934 Donner, Samuel, 99 Pratt.
1938 Donovan, William Francis, 47 Main.
1937 Duffy, Leo Thomas, 214 Franklin ave.
1923 Dunne, Richard Edwin, 30 Farmington ave.
1938 Durkee, Ralph Everett Jr., 179 Allyn.
1916 Dwyer, William, 18 Asylum.
1927 Elliott, Kirker Gregory, 631 Park.
1937 Ellison, Frederick Speirs, 50 Farmington ave.
1895 Elmer. Edward Oliver, 1731 Park.
1914 Emmett, Francis Arthur, 410 Asylum.
1937 Fagan, Francis X., 68 Pratt.
1933 Farland, Victor Louis, 54 Pratt.
1919 Fay, William James, 179 Allyn.
1929 Felty, Augustus R., 846 Asylum ave.
1934 Finley, George Clark, 50 Farmington ave.
1913 Flaherty, Claude Vincent, 50 Farmington ave.
1938 Foote, Franklin Manly, 165 Capitol ave.
1931 Friery, Clarence Milton, 110 Greenfield.
1919 Furniss, Henry Watson, 1335 Main.
1927 Gaberman, David, 179 Allyn.
1937 Galinsky, David, 853 Wethersfield ave.
1921 Garland, Robert Bernard, 597 Broad.
1940 Garofalo, Mario L., St. Francis Hospital.
1898 Gill, Michael Henry, 36 Pearl.
1922 Gills, William Lee, 179 Allyn.
1934 Giorgi, Nicholas Anthony, 61 Edwards.
1937 Giuliano, Sebastian, 468 Franklin ave.
1935 Glass, George Courtenay, 476 Farmington ave.
1934 Glaubman, Henry Mitchell, 20 Lenox.
1927 Goff, Charles Weer, 30 Farmington ave.
1936 Gold, Louis Henry, 412 Farmington ave.
1930 Goldenberg, Jacob Joseph, 832 Albany ave.
1933 Goodell, Robert Alvan, 79 Elm.
1900 Goodrich, Charles Augustus, 5 Haynes.
1919 Gosselin, George Adelor, 50 Farmington ave.
1935 Gould, Max Martin, 434 Main.
1923 Grau, Leroy Charles, 700 Main.
1923 Graves, James Chapman, 700 Main.
1924 Griswold, Matthew Hammond, 165 Capitol ave.
1921 Grosvenor, Frank Livingston, 700 Main.
1930 Hall, Llewellyn, 79 Elm.
1939 Hall, Wendell Charles, 179 Allyn st.
1913 Harrington, Amos Thomson, 43 Farmington ave.
1938 Harris, Louis David, 242 Trumbull.
1936 Harvey, Daniel Foster, 218 No. Beacon.
1930 Hastings, Louis Pease, 370 Collins.
1908 Hatheway, Clarence Morris, 110 High.
1937 Hazen, Donald Robert, 179 Allyn.
1939 Hennessy, James Joseph, Cedarcrest.
1907 Hepburn, Thomas Norval, 179 Allyn.
1930 Heyman, Joseph, 650 Main.
1934 Hirschfield, Otto Max, 1037 Albany ave.
1931 Hirshberg, Manuel Shelton, 650 Main.

1925 Hoffman, Charles Curtis, 700 Main.
1924 Hogan, Walter Louis, 750 Main.
1939 Hollinshead, Joseph Bentley, 1018 Farmington ave.
1929 Holt, Kerchival Rogers, 50 Farmington ave.
1930 Holtz, Raymond Sidney, 242 Trumbull.
1934 Horning, Benjamin Graham, 550 Main.
1935 Hough, Perry Tyler, 179 Beacon.
1922 Howe, Glover Elbridge, 179 Allyn.
1936 Hurwitz, George Hillel, 75 Pearl.
1920 Hurwitz, Herman Max, 75 Pearl.
1917 Hutchinson, James Elder, 125 Trumbull.
1938 Hutton, Gordon Hobbs, 200 Retreat ave.
1937 Irving, James Grant, 151 Farmington ave.
1939 Jackson, Allen F. 2137 Main.
1934 James, Lewis Paul. 68 Pratt.
1912 Jarvis, Henry Gildersleeve, 179 Allyn.
1930 Jones, Frank Stafford, 179 Allyn.
1928 Kalin, Jacob Isaac, 286 Church,
1933 Kardys, John Albert, 487 Main.
1935 Karotkin, Robert Harold, 839 Albany ave.
1935 Kaschmann, Joseph, 42 Asylum.
1937 Katz, Dewey, 99 Pratt.
1924 Katz, Henry, 750 Main.
1926 Keefe, George Gregory, 30 Sisson ave.
1934 Keefe, Raymond Starkey, 272 Franklin ave.
1934 Keefe, Walter Joseph, 30 Sisson ave.
1908 Keith, Albert Russell, 50 Farmington ave.
1920 Kelly, Claude Currie, 179 Allyn.
1930 Kendall, Ralph Emerson, 20 So. Hudson.
1927 Kilbourn, Austin, 580 Asylum.
1920 Kilbourn, Joseph Birney, 36 Pearl.
1906 Kingsbury, Isaac William, 125 Trumbull.
1937 Klieman, Abraham Ober, 750 Main.
1932 Klein, Abraham Arthur, 509 Farmington ave.
1925 Knowlton, Millard, 165 Capitol ave.
1930 Kunkel, Frederick Earle, 179 Allyn.
1901 Lampson, Edward Rutledge, 179 Allyn.
1938 Lampson, Rutledge Starr, 179 Allyn.
1913 Landry, Arthur Bernard, 50 Farmington ave.
1926 Landry, Benedict Bernard, 50 Farmington ave.
1929 Larrabee, John Whitfield, 650 Main.
1895 Lawton, Franklin Lyman, 580 Farmington ave.
1920 Leichner, William, 66 Farmington ave.
1933 Levin, Albert Eliott, 242 Trumbull.
1935 Levine, Sinclair Simcha, 54 Church.
1938 Lewis, Henry Ryle, 200 Retreat ave.
1937 Lischner, Moses David, 650 Main.
1934 Little, Milton Frederick, 49 Pearl.
1915 Locke, Harry Leslie Franklin, 179 Allyn.
1923 Luby, Thomas John, 410 Asylum.
1930 Lynch, John Francis, 99 Pratt.
1913 Madden, Leon Irving, 50 Farmington ave.
1919 Maislen, Samuel, 2138 Main.
1931 Mancoll, Morris Max, 242 Trumbull.
1932 Maranzini Samuel, 763 Albany ave.
1930 McClellan, Wilbert Ernest, 750 Main.
1898 McCook, John Butler, 390 Main.
1936 McCormack, Christopher Joseph, 50 Farmington ave.
1938 McCrann, Donald Joseph, 50 Farmington ave.
1934 McDermott, John Francis, 750 Main.
1933 McGrath, John Francis, 663 Maple ave.
1934 McLean, John Joseph, 650 Main.
1932 McLellan, Philip Garretson, 683 Asylum ave.
1935 McNulty, Terence Francis, 21 Sisson ave.
1907 McPartland, Patrick Farrell, 410 Asylum.
1916 McPherson, Sidney Horace, 4 Atwood.
1933 Middlebrook, Louis Francis Jr., 689 Asylum ave.
1916 Miller, James Raglan, 179 Allyn.
1933 Mirabile, Charles Samuel, 179 Allyn.
1938 Montano, Charles Carl, 525 Main
1937 Montano, Rocco Anthony, 242 Trumbull.
1909 Morrissey, Michael Joseph, 18 Asylum.
1939 Moxness, Bennie Arthur, 165 Capitol ave.
1927 Moylan, Thomas Patrick, 50 Farmington ave.
1930 Moyle, Henry Brown, 488 Main.
1935 Murphy, Thomas Francis, 619 Park.
1897 Naylor, James Henry, 1 Main.
1938 Neidlinger, William James, 751 Asylum ave.
1926 Oberg, Frank Thorwald, 689 Asylum ave.
1923 O'Connell, John Francis, 865 Park.
1928 O'Connell, Maurice Francis, 50 Farmington ave.
1902 O'Flaherty, Ellen Pembroke, 140 Main.
1928 Ogden, Ralph Trafton, 179 Allyn.
1931 Olmstead, John Gerald Maurice, 404 Farmington ave.
1938 O'Malley, Martha Alice, 165 Capitol ave.
1937 O'Neil, Charles William, 18 Asylum.
1921 Osborn, Stanley Hart, 165 Capitol ave. Home address: 41 Brace rd., W. Hartford.
1927 Osmond, Robert Hunter, 50 Farmington ave.
1906 Outerson, Richard Ambrose, 50 Farmington ave.
1938 Padula, Vincent Domenica, 132 N. Britain ave.
1933 Paladino, Joseph Salvator, 300 Franklin ave.
1919 Parker, John Woodcock, 84 Forest.
1926 Partridge, Winthrop Prescott, 403 Farmington ave.
1938 Peacock, Albert Upham, 751 Asylum ave.
1933 Phelps, Maxwell Overlock, 594 Farmington ave.
1937 Phelps, Paul Stetson, State Tuberculosis Commission, State Office Building.
1939 Phillips, Paul Lange, 333 Washington ave.
1929 Pike, Maurice Mitchell, 179 Allyn.
1934 Preston, Thomas Raymond, 65 Kenyon.
1934 Priddy, Foster Eugene, 30 Farmington ave.
1936 Quarrier, Sidney Sayre, 751 Asylum ave.
1923 Radin, Morris Jacob, 650 Main.
1928 Radom, Myron Michael, 242 Trumbull.
1923 Rankin, Bertrand Fred, 57 Pratt.
1913 Reardon, William Francis, 750 Main.
1934 Reidy, David Dillon, 750 Main.
1927 Resnisky, Andrew Francis, 57 Pratt.
1928 Reynolds, Harry St. Clair, 410 Asylum.
1916 Reynolds, Harry Stephen, 18 Asylum.
1930 Reynolds, Robert Gardner, 179 Allyn.
1922 Roberts, Douglas James, 179 Allyn.
1932 Robinson, Albert James, 55 Elm.
Roche, Arthur F. 50 Farmington ave.
1934 Rollins, Henry Brock, 140 Garden.
1932 Romaniello, Rocco John, 415 Hillside ave.
1909 Rooney, James Francis, 410 Asylum.
1936 Rosenbaum, George Jonas, 647 New Britain ave.
1938 Rosenthal, Ernest, 18 Asylum.
1935 Roth, Frank Edward, 650 Main.
1900 Rowley, Alfred Merriman, 179 Allyn.

1910 Rowley, John Carter, 1046 Asylum ave.
1907 Rowley, Robert Lee, 79 Elm.
1921 Russell, George Gardiner, 179 Allyn.
1936 Ryan, Francis James, 63 Webster.
1926 Salvin, Benjamim Lloyd, 242 Trumbull.
1937 Sayers, John Joseph, 656 Park,
1923 St. John, Leopold Albert, 25 Charter Oak ave.
1932 Samponaro, Nicholas, 650 Main.
1928 Scafarello, Peter Joseph, 410 Asylum.
1932 Schaefer, Abraham Maurice, 262 Maple ave.
1920 Shaefer, Jacob, 750 Main.
1934 Schuman, David Harold, 909 Albany ave.
1923 Scudder, Winthrop Davis, 179 Allyn
1887 Segur, Gideon Cross, 67 Farmington ave.
1932 Seibert, Alfred Frank, 700 Main
1920 Shafer, Alexander Samuel, 68 Pratt
1928 Shaw, George Hammil, 700 Main
1920 Shea, Daniel Edward, 750 Main
1933 Shulman, David Nathaniel, 422 Farmington ave.
1932 Sigal, Jacob Bernard, 99 Pratt
1936 Slossburg, David Seymour, 541 Park
1925 Smith, George Mortimer, 700 Main
1939 Smith, Wilson Fitch, 51 Farmington ave.
1937 Sneidman, George Irving, 18 Asylum
1929 Snelling, Pinckney Welch, 179 Allyn
1938 Souther, Susan Page, State Office Building.
1937 Spekter, Louis, 165 Capitol ave.
1921 Spillane, Bernard, 30 Farmington ave.
1927 Standish, Erland Myles, 179 Allyn
1897 Standish, James Herbert, 701 Albany ave.
1931 Standish, Welles Adams, 701 Albany ave.
1905 Starr, Robert Sythoff, 179 Allyn
1930 Steincrohn, Peter Joseph, 705 Asylum ave.
1902 Steiner, Walter Ralph, 646 Asylum ave.
1935 Stempa, Henry, "Cedarcrest."
1930 Stephenson, Charles Whattles, 179 Allyn
1938 Stolzheise, Ralph Merwin, 200 Retreat ave.
1903 Storrs, Eckley Raynor, 179 Allyn
1923 Storrs, Ralph Warren, 179 Allyn
1923 Stoughton, Dwight Harold, 247 S. Whitney.
1908 Swan, Horace Cheney, Trinity College
1914 Sweet, John Henry Throop, Jr., 179 Allyn
1905 Swett, Paul Plummer, 4 Atwood
1932 Talbot, Henry Pierce, 165 Capitol ave.
1930 Taylor, Andrew, 179 Allyn
1906 Taylor, Maude Winifred, 914 Asylum ave.
1921 Thenebe, Carl Leonard, 68 Pratt
1922 Thompson, Hartwell Greene, 179 Allyn
1938 Tonken, Louis Clarence, 485 Farmington ave.
1938 Tovell, Ralph Moore, Hartford Hospital.
1930 Townsend, Wilmot Charles, 50 Farmington ave.
1912 Truex, Edward Hamilton, 99 Pratt
1908 Tuch, Morris, 99 Pratt
1907 Turbert, Edward Joseph, 703 Asylum ave.
1937 Unsworth, Arthur Charles, 49 Pearl
1933 Urrichio, Joseph George, 260 Wethersfield ave.
1908 Vail, George Francis, 36 Pearl
1923 VanKleeck, Euen, 700 Main
1904 VanStrander, William Harold, 179 Church
1926 VanWart, William Haley, 650 Main
1917 Vernlund, Carl Frithiof, 179 Allyn
1921 Vershbow, Nathan, 28 Sisson ave.
1939 Wagner, Robert Lowell, 200 Retreat ave.
1914 Waite, Robert Lester, 68 Pratt
1932 Wallace, Charles Kenneth, 700 Main
1937 Walton, Loftus Linwood, 179 Allyn
1932 Warring, Howard Lewis, 1756 Main
1934 Weiner, Julius Gills, 750 Main
1931 Weisenfeld, Nathan, 169 Church
1936 Weissenborn, Walter, 50 Farmington ave.
1907 Welch, Thomas Francis, 50 Farmington ave.
1920 Weld, Stanley Burnham, 179 Allyn
1916 Wells, Donald Breckinridge, 580 Asylum
1922 Wentworth, John Alexander, 50 Farmington ave.
1924 Whalen, Edward Joseph, 750 Main
1938 White, Benjamin Vroom, 179 Allyn
1907 Wiedman, Otto George, 179 Allyn
1931 Wienski, John Casimer, 502 Park
1935 Wilson, Charles Christopher, 249 High
1907 Wilson, James Cornelius, 179 Allyn
1930 Wilson, William Augustus, 683 Asylum ave.
1904 Witter, Orin Russell, 179 Allyn
1933 Wood, Frank Oliver, 404 Farmington ave.
1934 Woodford, Chester North, 703 Asylum ave.
1923 Woodson, Jacob Tyree, 179 Allyn.
1916 Worthen, Thacher Washburn, 179 Allyn
1922 Wright, William Witter, 700 Main
1932 Wulp, George Adolf, 50 Farmington ave.
1912 Yergason, Robert Moseley, 50 Farmington ave.
1939 Yost, Orrin Rose, 200 Retreat ave.
1938 Young, William Greenhill, 200 Retreat ave.
1928 Zariphes, Constantine Argyros Paleslogos, 96 Main
1934 Zeman, Burnhardt, 1269 Main

MANCHESTER

1931 Aiken, Sidney, 489 Main
1924 Boyd, Howard, 935 Main
1939 Conlon, William Linas, 15 Main
1936 Keeney, Robert Raymond, Jr., 791 Main
1925 Knapp, Robert Phineas, 147 Hartford rd.
1937 Sundquist, Alfred Bernhardt, 843 Main
1936 Zaglio, Edmond Robert, 12 Myrtle

South Manchester

1926 Caldwell, David Manchester, 935 Main
1926 Friend, Amos Edgar, 935 Main
1927 Higgins, Edwin Carlton, 875 Main
1921 Lundberg, George Albin Ferdinand, 755 Main
1908 May, George William, 186 E. Center
1916 Moore, Demarquis DeCasso Ye Rujo, 689 Main
1930 Moriarty, Mortimer Emmett, 905 Main

NEW BRITAIN

1932 Benoit, Raoul Joseph, 272 Main
1934 Bernstein, Dwight J., 55 West Main
1930 Blogoslawski, Walter Joseph, 419 Main
1909 Bodley, George Houghton, 155 W. Main
1935 Bristoll, Donald Andrews, 55 W. Main
1940 Buccheri, Francis S., 419 Main
1927 Buol, Robert Stanley, 99 W. Main
1935 Chalmers, Harriet Elizabeth, 45 Walnut
1926 Chernaik, Samuel Julius, 300 Main
1913 Cooley, Clifton Mather, 44 S. High
1939 Daley, Louis W., 99 W. Main
1938 Dalton, George Henry, 99 W. Main
1931 Darrow, John Edward, 55 W. Main
1928 Donnelly, Stephen Patrick, 55 W. Main
1934 Dray, Edward Joseph, 259 Main

1915 Dunn, George Washington, 55 W. Main
1936 Enander, Fred Conrad, 25 Arch
1923 Flanagan, William Francis, 55 W. Main
1931 Geeter, Isadore Stolper, 92 Grand
1921 Grant, Arthur Sheldon, 55 W. Main
1937 Hart, Carl J., 259 Main
1930 Kalett, Joseph, 99 W. Main
1924 Kinsella, Michael Allen, 52 Main
1926 Lekston, Roman Francis, 197 W. Main
1931 Marsh, Milton Loveland, 272 Main
1930 Matteis, Joseph Theodore, 55 W. Main
1939 McMahon, George William, 272 Main
1934 Michalowski, Valerian Stanislaus, 561 Main
1937 Miller, Harry Bernard, 81 W. Main
1935 Moorad, Philip Jacob, 55 W. Main
1912 Morrissey, William Thomas, 55 W. Main
1923 Mouradian, Marion Garoudy, 87 Prospect
1938 Orbach, Egmont Julius, 81 W. Main
1939 Paolillo, Charles Gerald, 99 W. Main
1939 Parlato, H. Anthony, 99 W. Main
1938 Perakos, George Peter, 300 Main
1939 Pola, William Edward, 99 W. Main
1930 Pullen, Richard Woollard, 55 W. Main
1930 Purney, John, 99 W. Main
1936 Resnik, Edward, 166 Main
1930 Shechtman, Charles Theodore, 81 W. Main
1931 Schupack, Samuel David, 99 W. Main
1938 Scully, Roger Tehan, 55 West Main
1930 Slysz, Ladislaus Bernard, 589 Main
1928 Smith, Vincent Joseph, 55 W. Main
1936 Squilloacote, Vincent Joseph, 33 So. High
1938 Sullivan, Charles Noyes, 55 W. Main.
1940 Tisher, Paul Winslow, 99 West Main
1935 Tokarczyk, John Joseph, 32 North
1928 Waskowitz, David, 81 W. Main
1932 White, John Cowles, 55 W. Main

NEWINGTON

1938 Gray, Harry Joshua, U. S. Veterans Administration
1936 Maher, Thomas Francis, Veterans Administration Facility
1934 Sills, Theodore Hopkins, 866 Main

PLAINVILLE

1878 Bull, John Norris, 57 Whiting
1931 Cook, George Francis, 4 East Main
1931 Frost, Lawrence Hubbard, 98 W. Main
1934 Menousek, Joseph Albert, 14 E. Main
1938 Tortolani, Aresto Peter, 75 E. Main

PLANTSVILLE

1937 Connor, George Michael, 772 S. Main

ROCKY HILL

1904 Moser, Oran Alexander, Elm

SIMSBURY

1925 Murphy, Owen Lee, Weatogue
1932 Stretch, James Edison, Hopmeadow

SOUTHINGTON

1935 Dudac, Thomas William, 9 Center
1933 Gura, George Michael, 22 Main
1935 Nagle, William Thomas, 23 Woodruff
1929 Simmons, Eric Melville, 93 Main
1929 Thalberg, Reuben Edward, 32 N. Main

SUFFIELD

1938 Coates, Stephen Paul, 328 Main
1929 Levy, William, 339 Main
1930 Upson, William Hart, 394 Main

UNIONVILLE

1937 Dunne, Edward Patrick, Main

WEST HARTFORD

1931 Case, Edward Percy, 28 Brunswick ave.
1932 Crawley, George Andrew, 330 Park rd.
1928 Cushman, Laurence Arnold, 23 S. Main
1922 Davis, James Edward, 1961 Boulevard
1910 Denne, Thomas Harmon, 39 N. Main
1926 Glazier, J. Raymond, 26 Sequin rd.
1939 Gray, Albert Stanley, 1271 Farmington ave.
1930 Griggs, John Bolter, 38 Orchard rd.
1932 Lundborg, Francis Ludwig, 31 N. Main
1935 MacLean, Ethel Margaret, 32 Bishop rd.
1935 Martin, John Garthwaite, 7 S. Main
1939 Murphy, Thomas Denis, 957 Farmington ave.
1930 Parshley, Philip Ford, 20 S. Quaker lane.
1937 Rogers, Frederick Peckham, 783 Farmington ave.
1924 Root, Maurice Timothy, 51 N. Main
1935 Root, Sophie Andrews, 51 N. Main
1901 Smith, Earl Terry, Sunset Farm
1935 Standish, Hilda Crosby, Greenridge Lane, Sunset Farms
1936 Stewart, Lester Quentin, 69 S. Main
1937 Tait, Arthur Alfred, 333 Park rd.
1934 Winters, John Thomas, 3 S. Main

WETHERSFIELD

1938 Carvey, Edward Vincent, 28 Marsh
1933 Howard, Harold Amasa, 330 Main
1924 Ingraham A. Elizabeth, 302 Wolcott Hill rd.
1927 Smith, William Bowers, 91 Center
1932 Storms, William Frederick, 147 Main

WINDSOR

1930 MacCready, William Harold, 38 Elm
1939 Monacella, John Manilla, 18 Elm
1924 Pratt, Aaron Paul, 253 Broad

WINDSOR LOCKS

1921 Coyle, Anna E. H., 16 Church
1937 Coyle, Bruce James, 2 Chestnut
1934 Whitford, Warren, 88 Spring

OUT OF COUNTY

1911 Cobb, Albert Edward, Canaan.
1938 Curtis, Burr H., 25 Prospect pl., N.Y.C.
1900 Enders, Thomas Burnham, Mystic
1932 Filson, Ralph Marshall, 107 Tullamore rd., Garden City, L. I., N.Y.
1939 Gourson, Nathaniel Edward, 4400 E. Slauson ave., Maywood, California
1936 Lewis, Samuel D., 515 E. 4th St., Brooklyn, N.Y.
1928 Mahoney, Daniel F.C., P.O. Box 908. Palm Springs, Calif.
1902 Purinton, Charles Oscar, U. S. Veterans Hospital, Sunmount, N. Y.
1939 Sharp, Lewis I., 408 East 58th St., N.Y.C.
1937 Twaddle, Paul H. Penn. Hospital, 8th and Spruce St., Phila., Pa.
1934 Watson, William James, Apt. 410, 4111 Walnut st., Phila. Pa.
1923 Walker, William Hastings, Newtown
1938 Whitcomb, Benjamin Bradford, New Haven Hospital, New Haven

Total number 532

LITCHFIELD COUNTY

President, Roy V. Sanderson, M.D. 570 Main Street, Winsted
Vice-President, Herbert C. Oelschlegel, M.D., 19 Maiden Lane, Torrington.
Secretary, W. Bradford Walker, M.D., Cornwall.
Councilor, Charles H. Turkington, M.D., On-the-Green, Litchfield.

Censors
(One elected annually for a term of three years)
1941 Harry B. Hanchett, M.D., 55 Main Street, Torrington.
1942 Frederic W. Wersebe, M.D., Washington.
1943 Jerome S. Chaffee, M.D., Sharon Hospital, Sharon.

Committee on Public Policy and Legislation
(Elected annually)
Sanford H. Wadhams, M.D., 908 Main Street, Torrington, *Chairman.*
Elias Pratt, M.D., 27 Daycoeton Place, Torrington.
Charles H. Turkington, M.D., On-the-Green, Litchfield.

Committee on Medical Ethics and Deportment
(Appointed by President until removed or successor appointed)
Harry B. Hanchett, M.D., 55 Main Street, Torrington, *Chairman.*
Jerome S. Chaffee, M.D., Sharon Hospital, Sharon.
Winfield Wight, M.D., Goodwin Court, Thomaston.
Elias Pratt, M.D., 27 Daycoeton Place, Torrington.
Charles H. Turkington, M.D., On-the-Green, Litchfield.
W. Bradford, Walker, M.D., Cornwall, *Recorder.*
Annual Meeting, Fourth Tuesday in April.
Semi-Annual Meeting, First Tuesday in October.

CORNWALL

1940 Walker, Robert
1922 Walker, Wilmarth Bradford.

Cornwall Bridge

1938 Clarke, William Cogswell
1931 Evarts, Josephine, Warren rd.

KENT

1938 Bruyere, Paul Tulane, Kent School.

LITCHFIELD

1921 Childs, Albert Ewing, West
1935 Kilgus, John Frank, Jr., 80 West
1910 Turkington, Charles Henry, On-the-Green.
1896 Warner, Charles Norton, North
1939 Warner, Charles Norton, Jr., North
1936 Wray, Edward Halloway, Jr., Torrington rd.

NEW HARTFORD

1937 Ashley, Homer Champion, Main

NEW MILFORD

1938 Day, Rupert S.
1938 Ignace, Stephen J., 40 Church
1939 C. George LaTaif, 20 Bridge
1938 Stevens, Howard G.

NORFOLK

1937 Barstow, Richard Iddings, The Village Green
1909 Pinney, Almon William, Greenwoods rd., E.
1934 Ursone, Frank Domenico, Greenwoods rd., W.

NORTH CANAAN

Canaan

1929 Adam, Forbes Sampson.
1935 Eliott, John Richard.
1924 Sellew, Robert Cowan.
1938 Sellew, Robert Cowan, Jr.

PLYMOUTH

Terryville

1913 Lawton, Richard John, 9 N. Main
1939 Wilcox, Lloyd Mather, 19 Maple

SALISBURY

Lakeville

1933 Herrick, Francis Leach
1923 Peterson, Clark Kimball
1936 Wieler, Harry Julius, Hotchkiss School

SHARON

1904 Chaffee, Jerome Stuart, Sharon Hospital
1931 Hansell, Howard Russell, W. Main

THOMASTON

1938 Atha, Henry George, 44 Union
1928 Curran, Harold Joseph, Main
1903 Hazen, Robert, 45 Union
1910 Kane, James Hugh, 205 S. Main
1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

1898 Barker, Abram James, 216 Main
1937 Bienkowski, Joseph George, 40 Main
1898 Carlin, Charles Henry, 236 Main
1930 Danaher, Thomas Joseph, 106 Litchfield
1935 Garston, Louis Edward, 49 Main
1931 Giobbee, Michael Edward, 24 E. Main
1936 Goldberg, Isadore Solomon, 5 Water
1908 Hanchett, Harry Bigelow, 51 Main
1936 Hill, Emerson Stanley, 51 Main
1917 Kennedy, William Clement, 106 Main
1938 Kott, Joseph Henry, 18 Pearl
1936 LoRusso, Domenico Leonardo, 40 Main
1938 Murcko, William John, 497 Main
1923 Oelschlegel, Herbert Charles, 19 Maiden lane
1938 Orlowski, Andrew William, 40 Main
1923 Polito, Frank Leonard, 16 Litchfield
1887 Pratt, Elias, 27 Daycoeton pl.
1904 Ryan, Timothy Mayher, 24 Mason
1936 Sutherland, Francis Alexander, 24 Mason
1917 Thomson, Thomas Leonard, 24 Mason
1898 Wadhams, Sanford Hosea. 908 Main
1917 Weed, Floyd Albert, 199 Main

WASHINGTON

1927 Jackson, Arthur Hartt
1908 Wersebe, Frederic William

WATERTOWN

1936 Cleary, Harold John, Main
1897 Loveland, Ernest Kilborn, 48 North
1922 Martin, James Smith
1936 Meyers, Royal Abbott, 429 Main
1919 Reade, Edwin Godwin, 429 Main
1937 Reichenbach, Frank, 429 Main

WINCHESTER

Winsted

1938 Baker, Philip George, 442 Main
1936 Cornelio, Francis Joseph, 153 Main
1933 Derwin, James Joseph, 350 Main

1915 English, Chester Ferrin, 64 Main
1937 Gallo, Francis, 384 Main
1927 Herman, Donald Warner, 486 Main
1936 Levy, Aaron, 384 Main
1912 Reidy, Maurice Joseph, 350 Main
1922 Sanderson, Roy Voter, 570 Main

WOODBURY

1913 Allen, Howard Sanford

OUT OF COUNTY

1881 Platt, William Logan, State Hospital, P. O. Box 476, Norwich.
1914 Woodward, Harold Burton, 321 Main St., Bristol

Total number 78

MIDDLESEX COUNTY

President, Carl C. Chase, M.D., 121 Main, Middletown
Vice-President, Harry S. Frank, M.D., 144 Washington, Middletown.
Secretary, Charles Russman, M.D., Connecticut State Hospital, Middletown.
Councilor, Alfred N. Sweet, M.D., 50 Crescent st., Middletown.

Censors

(One elected annually for a term of three years)

Chester A. Van Cor, Box 361 Middletown
Louis O. LaBelle, 612 Main st., Middletown

Committee on Public Policy and Legislation

(Appointed until removed or successor appointed)

G. Mansfield Craig, *President*, 363 Main Street, Middletown
Carl Chase, *Vice-President*, Professional Building, Middletown
Charles Russman, *Clerk*, Conn. State Hospital, Middletown
Harry S. Frank, 144 Washington Street, Middletown

Committee on Medical Ethics and Deportment

(One elected annually to serve for three years)

1941 Julius H. Grower, M.D., 164 Court st., Middletown
1942 Louis Soreff, M.D., 15 Main Street, East Hampton.
1943 Frederick E. Tracy, M.D., 120 Pearl Street, Middletown
1944 Lloyd W. Minor, M.D., 119 Main Street, Middletown
1944 Alfred N. Sweet, M.D., 50 Crescent Street, Middletown

Annual Meeting, Second Thursday in April.
Semi-Annual Meeting, Second Thursday in October.

CHESTER

1935 Lieberman, David Leonard.

CLINTON

1937 Rindge, Norman Pember, 49 Pearl
1935 Stone, Harry Russell, 67 West Main

CROMWELL

1934 Couch, Frank Hallock, Cromwell Hall.
1934 Couch, Mildred Warden, Cromwell Hall.
1928 Nelson, Walter Nathaniel, 76 Main
1925 Pierson, Emily Miller, 107 Main

DURHAM

1940 Sherwood, Henry Main

EAST HADDAM

1924 Crook, Joseph Bruce, P.O. Box No. 133

MOODUS

1935 Horsefield, Thomas Earl, P.O. Box 40

EAST HAMPTON

1936 Gardner, Norman Homer
1934 Soreff, Louis, 15 Main

ESSEX

1903 Bradeen, Frederick Barton, P.O. Box No. 221
1908 Davis, Charles Clarence, 5 South Main
1938 Scott, J. Clifford, 20 West ave.

HADDAM

1893 Mead, Kate Campbell Hurd

HIGGANUM

1905 Burr, Noah Arthur

MIDDLETOWN

1933 Beauchemin, Joseph Adelard, Connecticut State Hospital
1937 Calhoun, Hazen Albert, Jr., 647 Main
1926 Chase, Carl Clarence, 121 Main
1928 Compson, Florence Eberly Mentzer, Connecticut State Hosp.
1924 Craig, George Mansfield, 119 Main
1935 Elliott, George Albert, Connecticut State Hosp.
1912 Fauver, Edgar, 55 Mt. Vernon.
1933 Fekety, Stephen Henry, 675 Main
1921 Felt, Paul Revere, Connecticut State Hosp.
1900 Fisher, Jessie Weston, 28 Crescent
1927 Frank, Harry Selig, 144 Washington
1931 Gissler, Norman Edwin, 164 Court
1927 Grower, Julius Harry, 164 Court
1920 Harvey, Carl Clifford, 119 Main
1924 Holley, Erving, Connecticut State Hosp.
1924 Joyce, William Michael, 121 Main
1928 LaBella, Louis Oronato, 612 Main
1920 Leak, Roy Lathen, Connecticut State Hosp.
1925 Loffredo, Louis, 77 Crescent
1929 Magnano, Joseph, 100 Broad
1940 McLeod, Christie Ellen, 28 Crescent
1934 Minor, Lloyd Wesley, 119 Main
1896 Murphy, James, 101 Broad
1896 Nolan, Daniel Andrew, 613 Main
1939 Palmieri, Mario Lorenzo, 43 So. Main
1928 Piasta, Peter Ferdinand, 602 Main
1889 Potter, Frank Edward, 160 College
1934 Roccapriore, Benjamin Anthony, 504 Main
1926 Russmann, Charles, Connecticut State Hosp.
1929 Speight, Harold Edmund, 642 Main
1924 Sweet, Alfred Norton, 70 Crescent
1933 Tracy, Frederick Erwin, 120 Pearl
1919 Van Cor, Chester Arthur, Connecticut State Hosp.
1933 Whiting, Harry St. John, Connecticut State Hosp.
1925 Wilder, Ella Annis, 80 S. Main
1922 Wrang, William Emil, 294 Main

OLD SAYBROOK

1905 Granniss, Irwin, P.O. Box 312.
1934 Greenberg, Aaron, Main

PORTLAND

1938 Prout, Edgar Bacon, 48 Bartlett
1933 Schwartz, Philip Edward, 309 Main
1932 Wagner, Carl Phillips, 25 Marlborough

SAYBROOK

Deep River

1939 Lobb, Russell Albert, 131 Main

1903 Pratt, Arthur Milton, P.O. Box 477
1932 Tate, William James, Elm

WESTBROOK

1939 McDermott, Terence Stephen, Horse Hill rd.

OUT OF COUNTY

1890 Coleburn, Arthur Burr, 5 Cannon Street, Norwalk
1938 Colomb, Anna Catherine, Box 6000; Torresdale P.O. Philadelphia, Pa.
1904 Kingman, James Henry, 96 Everit St., New Haven
1939 Sikes, Ralph Fuller, 74 Water Street, Guilford
1939 Wadsworth, George Leland, Howard State Hosp. Howard, R.I.

NEW HAVEN COUNTY

President, J. **Harold Root**, M.D., 103 North Main Street, Waterbury.
Vice-President, **Frederick N. Sperry**, M.D., 107 Whitney Avenue, New Haven
Secretary, **Ralph E. McDonnell**, M.D., 158 Whitney Avenue, New Haven.
Councilor, **Thomas P. Murdock**, M.D., 147 West Main Street, Meriden

Censors
(Elected annually)

Charles L. Larkin, M.D., 101 North Main Street, Waterbury
Raymond V. Quinlan, M.D., 5 State Street, Meriden.
Charles A. Breck, M.D., 176 North Main Street, Wallingford

(*Committee on Public Policy and Legislation*)
(Appointed annually by the President)

Charles W. Comfort, Jr., M.D., 27 Elm Street, New Haven
Charles W. Gaylord, Jr., M.D., 93 South Main Street, Branford
A. Nowell Creadick, M.D., 79 Trumbull Street, New Haven
James D. McGaughey, M. D., 261 Center Street, Wallingford
Charles L. Larkin, M.D., 101 North Main Street, Waterbury

Committee on Medical Ethics and Deportment
(Two appointed annually by the President
for a term of 3 years)

1941 **Anthony J. Hendillo**, M.D., 45 Trumbull Street, New Haven
1941 **Edward H. Kirschbaum**, M.D., 20 Grove Street, Waterbury
1942 **James D. McGaughey**, M.D., 261 Center Street, Wallingford
1942 **John S. Dye**, M.D., 111 West Main Street, Waterbury
1943 **Grover F. Powers**, M.D., 789 Howard Avenue, New Haven
1943 **Cole B. Gibson**, M.D., "Undercliff", Meriden

Annual Meeting, Fourth Thursday in April
Semi-Annual Meeting, Fourth Thursday in October

ANSONIA

1916 Aaronson, Michael S., 410 Main
1937 Alu, Anthony F., 290 Main
1935 Blumenthal, Edward Jedediah, 88 Main
1938 Casagrande, John J., 178 Main
1907 Parmelee, Edward Kibbe, 50 Main
1932 Renehan, John Michael, 100 Main
1924 Senfield, Maxon Major, 110 Main
1924 Steudel, Henry, 88 Main
1924 Thomas, John Joseph, 290 Main

BRANFORD

1934 Blanchard, Dana Lincoln, 87 Main
1931 Bodie, William Joseph, 146 Montowese
1917 Gaylord, Charles Woodward, 93 S. Main
1929 Levy, Nathan, 94 Main
1916 McQueen, Arthur Samuel, 187 Montowese

Pine Orchard

1919 Smith, George Milton

CHESHIRE

1926 Lindsay, John Crandall, State Reformatory
1923 Moore, Wilbur John, Maple ave.
1940 Neff, William E. Jr., Main
1939 Oxnard, Edward Warren, Maple ave.

DERBY

1916 Baldwin, Charles Tomlinson, 74 Fourth
1927 Burns, George Dewey, 272 Main
1940 D'Ambruoso, Dominic C., 3 Elizabeth
1885 Loomis, Frank Newton, 100 Atwater ave.
1910 Parlato, Michael Antonio, 270 Elizabeth
1929 Pepe, Carmen Thomas, 157 Minerva
1890 Pinney, Royal Watson, 116 Derby ave.
1914 Plunkett, Thomas Francis, 18 Elizabeth
1925 Rentsch, Samuel Burton, 61 Seymour ave.
1927 Scott, William Joseph, 58 Elizabeth
1940 Stygar, Joseph S., 272 Main
1910 Treat, William Howard, 258 Main

EAST HAVEN

1940 Balletto, Vincent, 265 Main
1940 Grenon, Ovilda A., 586 Thompson ave.
1924 Taylor, Robert Mitchell, 578 Thompson ave.

GUILFORD

1916 Smith, Frederic DeWitt, 55 Park

HAMDEN

1937 Case-Downer, Muriel, 95 Wayland
1936 Corey, Walter Van Arsdale, 1188 Whitney ave.
1926 Ematrudo, Frederick Roys, 1756 Whitney ave.
1904 Lay, Walter Sidders, 2320 Whitney ave.
1927 Lindsay, Merrill Kirk, 978 Ridge rd.
1927 Slater, Morris, 1100 Dixwell ave.

Mount Carmel

MADISON

1929 Hughson, Donald Thomas, Boston Post rd.
1908 Rindge, Milo Pember, Boston Post rd.

MERIDEN

1934 Affinito, Thomas, 128 W. Main
1929 Campbell, Sherbourne, 147 W. Main
1928 Caplan, Henry, 27½ W. Main
1939 Caplan, Max, 197 Cooke ave.
1937 Carey, William Clark, 61 Colony
1924 Carroll, William Edward, "Undercliff"
1937 Cohen, David Jerome, 3 Colony
1926 Conroy, Michael Joseph, 64½ E. Main
1939 de La Vergne, Paul Mason, "Undercliff"
1927 DeRosa, Sylvester Frank, 90 W. Main
1930 Foster, Edward Wendell, 147 W. Main
1921 Gibson, Cole Blease, "Undercliff"
1929 Hall, William Edward, 147 W. Main

1939 L'Heureux, Jerome A., 93 E. Main
1896 LaPointe, John William Henry, 56½ W. Main
1939 Liebow, Averill Abraham, 12 King
1907 Lockwood, Howard DeForest, 248 E. Main
1938 McCullough, Edward A., 53½ West Main
1934 Mekrut, Joseph Anthony, 34½ W. Main
1928 Mills, Bernard Litchfield, 94 E. Main
1934 Misuk, Joseph Francis, 489 Broad
1913 Murdock, Thomas Patrick, 147 W. Main
1921 Otis, Fessenden Newport, 165 W. Main
1920 Otis, Israel Sabine, 165 W. Main
1932 Pennington, Harry Freeman, 455 Broad
1937 Petrucelli, Rocco Joseph, 147 W. Main
1931 Pierson, Louis A., 199 W. Main
1916 Quinlan, Raymond Vincent, Lawton Bldg., 5 State
1913 Smith, David Parker, 199 W. Main
1935 Solomon, Charles Isadore, State School for Boys
1934 Strickland, Harold, 128 W. Main
1921 Tower, Arthur Augustus, 147 W. Main
1936 Van Antwerp, Lee Douglas, "Undercliff"
1921 Wilson, James Alfred, 61 Colony

MILFORD

1938 Barney, Walter Edward, 186 Broad
1932 Budau, John Harry Diederichs, 741 E. Broadway
1913 Fischer, William John Henry, 3 Lafayette
1929 Geib, Henry Albert, Zion Hill rd.
1932 Heady, Carlton Kellogg, 26 Cherry
1928 Hyde, Clinton John, 157 Gulf
1939 Lee, Frank Nelson, 56 Broad
1933 Stetson, Harry Warren, 114 Broad

DEVON

1934 Andrus, Oliver Burton, 531 Daytona ave

NAUGATUCK

1922 Duffy, Vincent Paul, 83 Meadow
1923 Hill, William Edward, 150 Meadow
1927 Johnson, Harold Albert, 297 Church
1936 Pine, Clifford Shepard, 14 Hillside ave.
1938 Reilly, Walter J., 170 Meadow
1937 Towne, Nehemiah Alvardo, 19 Hillside ave.
1926 Williams, Edward Everett, 269 Church

UNION CITY

1925 Curran, Edwin Russell, 364 N. Main

NEW HAVEN

1935 Abbey, Edward Augustin, 255 Bradley
1937 Abrashkin, Mortimer Dick, 1187 Chapel
1921 Alderman, Irving Saunders, 204 Park
1925 Allen, Edward Pratt, 27 Elm
1902 Allen, Millard Filmore, 65 Dixwell ave.
1893 Alling, Arthur Nathaniel, 257 Church
1919 Alpert, Reuben Harry, 1142 Chapel
1932 Amatruda, Frank Gabriel, 542 Chapel
1908 Arnold, Harold Sears, 442 Temple
1930 Arnold, Hermann Bruno, 1460 Chapel
1916 Baldwin, William Pitt, 1226 Chapel
1940 Barald, Fred Charles, 487 Dixwell ave.
1920 Barker, Creighton, 258 Church
1900 Barnes, William Samuel, 265 Church
1908 Barrett, William Joseph, 546 Chapel
1896 Bartlett, Charles Joseph, 183 Bishop
1936 Bassin, Alexander Lewis, 789 Howard ave.
1930 Batelli, Clement Francis, 161 Church
1925 Battista, Anthony William, 111 Osborn ave.
1934 Bayne-Jones, Stanhope, 333 Cedar
1909 Beck, Frederick George, 193 York
1926 Behan, Edmund Joseph, 1370 Chapel
1931 Benedict, Mary Kendrick, 85 Whitney ave.
1911 Bergman, Axel P., 27 Elm
1940 Berlowe, Max Llewellyn, 60 Trumbull
1920 Berman, Harry Loring, 1142 Chapel
1939 Bishop, Courtney Craig, 158 Whitney ave.
1907 Blake, Eugene Maurice, 303 Whitney ave.
1922 Blake, Francis Gilman, 789 Howard ave.
1927 Blodinger, Israel Edward, 1142 Chapel
1907 Blumer, George, 158 Whitney ave.
1911 Boardman, Albertus Kellogg, 441 Forbes ave.
1922 Boardman, Emma Irene, 161 Church
1926 Bodie, John Allen, 221 Columbus ave.
1939 Boisvert, Paul Leo, 1609 Chapel
1919 Bonoff, Zelly Adam, 1204 Chapel
1919 Bretzfelder, Karl Benjamin, 265 Church
1935 Brody, Bernard Stephen, 303 Whitney ave.
1938 Bruckner, William J., 129 Whitney ave.
1930 Bumstead, John Henry, 256 Bradley
1934 Canfield, Norton, 789 Howard ave.
1928 Capecelatro, Alfonso, 142 Columbus ave.
1916 Carelli, Genesis Frank, 27 Elm
1932 Celentano, Luca Eugene Humbert, 115 Howe
1892 Cheney, Benjamin Austin, 265 Church
1934 Claiborn, Louie Nixon, 303 Whitney ave.
1937 Clark, Mildred, H., 244 Sherman ave.
1938 Clarke, Clement Cobb, 158 Whitney ave.
1935 Climo, Samuel, 1172 Chapel
1923 Cobey, James Francis, 1210 Chapel
1922 Coffey, James Ryle, 216 Grand ave.
1925 Cofrances, Louis William, 190 Winthrop ave.
1901 Cohane, Jeremiah Joseph, 59 College
1904 Cohane, Timothy Francis, 400 Congress ave.
1924 Cohen, William, 1195 Chapel
1939 Cde, Clarence Hummer, 701 Howard ave.
1917 Collins, William Francis, 66 Trumbull
1921 Colwell, Howard Spencer, 129 Whitney ave.
1914 Comfort, Charles Williams, Jr., 27 Elm
1931 Connolly, Arthur James, 59 Trumbull
1914 Conte, Harry Albert, 5 Elm
1939 Conte, Mario Gero, 334 Grand ave.
1921 Cook, Robert Jay, 85 Whitney ave
1931 Corradino, Charles Louis, 516 Howard ave.
1921 Creadick, Abraham Nowell, 79 Trumbull
1936 Culotta, Charles Salvatore, 388 Orange
1940 Cutter, Herman Shepard, 425 Forbes ave.
1924 Dallas, Marion, 248 Bradley
1935 D'Amico, Michael, 303 Whitney ave.
1934 Darrow, Daniel Cady, 789 Howard ave.
1939 Davis, Jachin Boaz, 158 Whitney ave.
1920 Dayton, Arthur Bliss, 129 Whitney ave.
1920 Deming, Charles Kenneth, 257 Church
1922 Deming, Clyde Leroy, 789 Howard ave.
1925 Dennehy, William James, 1282 State
1908 Diefendorf, Allen Ross, 121 Whitney ave.
1938 Dobbs, William G. H. 1418 Chapel
1922 Duffy, William Core, 608 Whitney ave.
1923 Errico, Louis, 26 Elm
1925 Evans, Theodore Schlosser, 59 Trumbull
1935 Fenney, Philip William, 705 Dixwell ave.

1913	Ferguson, Robert John, 59 College
1892	Fems, Harry Burr, 333 Cedar
1929	Fiskio, Peter William, 307 Humphrey
1937	FitzSimons, Edmund Francis, 589 Howard ave.
1914	Flynn, Charles Thomas, 41 Trumbull
1917	Flynn, David Aloysius, 326 Grand ave.
1929	Flynn, Harold Aloysius, 464 Dixwell ave.
1888	Foote, Charles Jenkins, 257 Church
1929	Foster, Lewis Chandler, 256 Bradley
1925	Fox, James Charles, Jr., 789 Howard ave.
1924	Freedman, Barnett Philip, 322 George
1936	Freeman, David, 60 Trumbull
1937	Fry, Clements Collard, 109 College
1938	Geiger, Arthur Joseph, 789 Howard ave.
1939	Gendel, Benjamim Robert, 113 Sherman ave.
1937	Gentile, Angelo Louis, 601 Chapel
1920	Geraci, Lucian Arthur, 546 Chapel
1937	German, William John, New Haven Hosp.
1923	Gettings, James Augustus, 209 Whalley ave.
1924	Giamarino, Henry James, 532 Chapel
1923	Giannotti, Carl Charles, 214 Lafayette
1940	Gildea, Edwin Francis, 333 Cedar
1923	Giannotti, Carl Charles, 214 Lafayette
1940	Gildea, Edwin Francis, 333 Cedar
1926	Glazer, Morris, 1204 Chapel
1910	Goldberg, Samuel James, 43 Trumbull
1912	Goldman, George, 201 Park
1927	Goldstein, Morris, 451 George
1935	Goldstein, Richard Moses, 333 Cedar
1938	Goodman, Louis S., 333 Cedar
1924	Greenhouse, Barnett, 107 Whitney ave.
1927	Groark, Joseph Anthony, 145 Grand ave.
1931	Grodin, Herman Wolmer, 840 Howard ave.
1939	Guida, Francis Paul, 107 Whitney ave.
1936	Hankin, Morris Albert, 43 Trumbull
1930	Harris, Benedict Richard, 176 Dwight
1937	Harris, Jesse Samuel, 176 Dwight
1931	Harrison, Elizabeth Ross, 255 Bradley
1935	Hart, James Clement, 820 Elm
1920	Harvey, Samuel Clark, 789 Howard ave.
1937	Hathaway, John Seabury, 109 College
1916	Hendricks, Albert Ludwig, 26 Trumbull
1907	Henze, Carl William, 466 Orange
1925	Herrmann, Julian Bertram, 204 Park
1937	Hess, Orvan Walter, 79 Trumbull
1930	Higgins, Joseph John, 48 Dwigh
1922	Hillman, Maurice Manuel, 1249 Chapel
1927	Hippolitus, Jean DeFrancis, 1447 Chapel
1916	Hirata, Isao, 1455 Chapel
1924	Howard, Albert Joseph, 432 Whitney ave.
1935	Howard, Marion Edith, 789 Howard ave.
1915	Hynes, Frederick Henry, 195 Church
1903	Hynes, Thomas Vincent, 1441 Chapel
1914	Jack, Gabriel Joseph, 347 Orange
1924	Jack, John Louis, 412 Orange
1936	Jackson, Edith Banfield, 333 Cedar
1927	Jenkins, Ralph Hathaway, 59 College
1933	Johnson, Carl Edward, 158 Whitney ave.
1919	Johnson, Edgar Mayer, 73 Howe
1938	Jordan, Robert Hough, 59 Trumbull
1937	Kahn, Eugen, 333 Cedar
1938	Kennard, Margaret A., 333 Cedar
1901	Kilbourn, Clarence Leishman, 202 Blatchley ave.
1938	Klatskin, Gerald, 255 Bradley
1928	Klebanoff, Harry Erwin, 1497 Chapel
1917	Kleiner, Simon Bretzfelder, 315 Whitney ave.
1938	Klinghoffer, Kalmen Anselm, 789 Howard ave.
1940	Koufman, William B. 45 Trumbull
1935	Krosnick, Morris Yale, 1195 Chapel
1935	Kuh, Clifford, 31 Howe
1937	Kushlan, Samuel Daniel, 303 Whitney ave.
1940	Latimer, Marvin L., 129 Whitney ave.
1936	Lavietes, Paul Harold, 789 Howard ave.
1915	Lear, Maxwell, 1172 Chapel
1935	Leddy, Percy Allen, 109 College
1939	Lehman, Edward Burton, 1142 Chapel
1938	Leonard, John Charles, 789 Howard ave.
1923	Levin, Hyman Alexander, 1142 Chapel
1920	Levy, Daniel Frederick, 5 College
1923	Levin, Hyman Alexander, 1142 Chapel
1905	Lewis, Dwight Milton, 169 Church
1923	Lewis, Robert Morton, 52 Trumbull
1911	Line, Joseph Irving, City Hall
1934	Lindskog, Gustaf Elmer, 789 Howard ave.
1919	Little, Herman Clark, 303 Whitney ave.
1927	Logan, William Joseph, 412 Whalley ave.
1926	MacGready, Paul Beattie, 442 Temple
1878	Mailhouse, Max, 195 Church
1927	Marshall, Carter Lee, 198 Dixwell ave.
1928	Marvin, Harold Myers, 303 Whitney ave.
1921	Massa, Anthony Francis, 697 Elm
1931	Mastorianni, Luigi, 248 Bradley
1925	Maurer, Lloyd Leslie, 41 Trumbull
1920	Maynard, Harry Hilts, 882 Howard ave.
1934	McAlenney, Paul Francis, Jr., 79 Trumbull
1922	McDonnell, Ralph Edward, 158 Whitney ave.
1913	McGuire, William Charles, 104 Park
1899	McIntosh, Edward Francis, 307 Alden ave.
1940	Mendelsohn, William, 442 Temple
1916	Mendillo, Anthony Joseph, 45 Trumbull
1933	Mendillo, John Carleton Francis, 255 Bradley
1938	Mignone, Joseph, 388 Orange
1930	Mongillo, Frank, 5 Elm
1916	Morse, Arthur Henry, 789 Howard ave.
1922	Musselman, Luther Kyner, 215 Whitney ave.
1921	Nahum, Louis Herman, 1142 Chapel
1940	Nesbit, Robert Raymond, St. Raphael's Hosp.
1922	Newman, Joseph Thomas, 150 Shelton ave.
1914	Nichols, Ralph Wilbur, 57 Trumbull
1932	Nodelman, Jacob, 5 Elm
1920	O'Brien, William Henry Joseph, 265 Church
1922	O'Connor, Denis Stanislaus, 158 Whitney ave.
1885	Osborne, Oliver Thomas, 1155 Forest rd.
1931	Oughterson, Ashley Webster, 789 Howard ave.
1936	Palmieri, Michael Walter, 551 Howard ave.
1938	Parente, Leonard, 64 Trumbull
1929	Paul, John Rodman, 789 Howard ave.
1894	Peck, Robert Ellsworth, 1418 Chapel
1940	Perham, William Sidney, 58 Trumbull
1922	Perrins, Harlan Bassett, 59 Trumbull
1925	Peters, John Punnett, 789 Howard ave.
1927	Petrelli, Joseph, 455 Orange
1923	Philipson, Samuel, 61 Park
1909	Phillips, Frank Lyman, 405 Temple
1935	Piazza, George Joseph, 78 Orchard
1931	Pinn, Abraham Samuel, 75 Sherman ave.

1927 Poole, Allan King, 107 Whitney ave.
1938 Poverman, David, 67 Trumbull
1927 Powell, Wilson, 1266 Forest rd.
1925 Powers, Grover Francis, 789 Howard ave.
1934 Rademacher, Everett Stanley, 442 Temple
1903 Rand, Richard Foster, 246 Church
1903 Reilly, Francis Henry, 230 Church
1924 Riccitelli, Mariano Louis, 476 Howard ave.
1937 Robbins, Clarence Loveridge, 158 Whitney ave.
1929 Roberts, Frederick William, 129 Whitney ave.
1920 Rogers, Orville Forrest, 109 College
1929 Rogowski, Bernhard Albert, 75 Whitney ave.
1932 Rothschild, Morris Loeb, 265 Church
1937 Rubin, George Alan, 1150 Chapel
1914 Russell, Thomas Hubbard, 57 Trumbull
1922 Russell, Walter Irving, 317 Whalley ave.
1920 Russo, Joseph Daniel, 120 Blatchley ave.
1921 Ryder, William Harold, 185 Church
1933 Salinger, Robert, 256 Bradley
1910 Sanford, Charles Edwin, 265 Church
1939 Savarese, Melchior F. R., 41 Howe
1911 Scarborough, Marvin McRae, 47 Trumbull
1931 Scholl, Robert Frederick, 215 Whitney ave.
1924 Scott, Clifton Russell, 215 Whitney ave.
1920 Seabury, Robert Brewster, 64 Trumbull
1916 Segnalla, Ernest, 613 Chapel
1923 Serafin, Peter James, 809 State
1937 Shaffer, Thomas Eugene, 107 Whitney ave.
1928 Shay, Francis Leo, 368 Alden ave.
1923 Shea, Michael Stephen, 500 Howard ave.
1915 Sheahan, William Lawrence, 59 College
1929 Shure, Abraham Lewis, 85 Whitney ave.
1940 Sigel, Harry, 37 Sylvan ave.
1923 Silverberg, Samuel Joshua, 201 Park
1913 Skiff, Stuart Ernest, 1194 Chapel
1923 Smith, Charles Seaver, 59 College
1914 Smith, Marvin, 356 Humphrey
1926 Smith, Norman Nathaniel, 1558 Chapel
1927 Snurkowski, Charles Vincent, 487 Orange
1927 Sperandeo, Anthony, 538 Chapel
1896 Sperry, Frederick Noyes, 107 Whitney ave.
1939 Spinner, Samuel, 45 Trumbull
1907 Standish, Frank Billings, 193 York
1936 Stevens, Marvin Allen, 256 Bradley
1916 Stewart, Harry Eaton, 262 Bradley
1925 Stone, Emerson Law, 129 Whitney ave.
1920 Strauss, Maurice Jacob, 41 Trumbull
1897 Sullivan, John Francis, 1346 Chapel
1923 Sullivan, Thomas Joseph, 495 Orange
1921 Tanner, Monroe Julius, 26 High
1939 Tennant, Robert, 310 Cedar
1938 Thompson, Kenneth W., 789 Howard ave.
1936 Thompson, Lloyd James, 333 Cedar
1915 Thoms, Herbert, 789 Howard ave.
1911 Tileston, Wilder, 442 Temple
1922 Toole, Frank Edward, 419 Whalley ave.
1911 Tracy, Robert Graham, 593 Howard ave.
1925 Trask, James Dowling, 789 Howard ave.
1923 Tyler, Margaret, 158 Whitney ave.
1896 Verdi, William Francis, 27 Elm
1924 Vestal, Paul William, 79 Trumbull
1926 Wakeman, Edward Taylor, 129 Whitney ave.
1940 Warren, Edgar William, 109 College
1919 Weil, Arthur, 85 Whitney ave.
1902 Welch, Harry Little, 59 College
1907 Wheatley, Louis Frederick, 61 Trumbull
1916 Whiting, Leonard Clark, 121 Whitney ave.
1906 Whittemore, Edward Reed, 33 Whitney ave.
1936 Wies, Frederick Albert, 255 Bradley
1931 Willner, Otto, 61 Trumbull
1935 Wilson, Hugh Monroe, 789 Howard ave.
1931 Wilson, William Rives, 58 Trumbull
1939 Winkler, Alexander Woodward, 789 Howard ave.
1899 Winne, William Nelson, 1020 Whalley ave.
1921 Winternitz, Milton Charles, 310 Cedar
1922 Winters, Sidney, 1175 Chapel
1895 Wurtenberg, William Charles, 445 St. Ronan
1935 Yannett, Herman, 789 Howard ave.
1924 Yavis, John Constantine, 115 Dwight
1920 Yudkin, Arthur Meyer, 257 Church
1933 Zimmerman, Harry Martin, 310 Cedar

NORTH HAVEN

1913 Lane, William P., "The Cedars."
1940 Parrella, Louis A., Broadway
1923 Taylor, Sterling Price, Broadway and Post rd.

SEYMOUR

1938 Chobian, Joseph A., 159 Main
1934 Rogol, Oscar, 135 Main

WALLINGFORD

1935 Boyarsky, Harry Morton, 60 Center
1932 Breck, Charles Arthur, 176 N. Main
1908 Buffum, John Harold, 145 N. Main
1930 Carrozella John Christy, 50 S. Main
1905 Lyman, David Russell, Gaylord Farm Sanitorium
1911 McGaughey, James David, 261 Center
1916 Morriss, William Haviland, Gaylord Farm Sanatorium
1936 Murphy, Thomas Basil, 342 Center
1940 Pelz, Siegmund, 5 North Main
1925 Riordan, William James, 261 Center
1919 Sheehan, Mark Thomas, 1 Williams
1933 Wilson, George Campbell, Gaylord Farm Sanatorium

WATERBURY

1924 Allen, Harry Everett, 30 Prospect
1929 Atkins, Samuel Maurice, 63 Central ave.
1923 Audet, Charles Henry, 95 N. Main
1910 Barber, Walter Lewis, Jr., 87 N. Main
1937 Berman, Bernard Alfred, 161 N. Main
1908 Bevans, Theodore Frank, 111 W. Main
1931 Bizzozero, Orpheus Joseph, 20 Grove
1939 Bonner, Robert Alexander, 51 W. Main
1910 Brennan, Patrick Joseph, 135 W. Main
1928 Brown, Abe Solomon, 58 Central ave.
1894 Brown, Charles Henry, 57 N. Main
1940 Burke, Joseph Francis, 135 W. Main
1935 Collins, Joseph Osborn, Waterbury Hospital
1932 Corbett, Herbert John, 14 Central ave.
1928 Cottiero, Thomas, 21 Cooke
1940 Damiani, Rudolph A. 5 Cooke
1907 Deming, Dudley Brainard, 67 Willow
1912 Dillon, John Henry, 325 E. Main
1927 Dreher, Alfred Charles, 171 N. Main

1902 Dwyer, Patrick James, 95 N. Main
1917 Dye, John Sinclair, 111 W. Main
1927 Edlin, Charles, 24 Central ave.
1916 Egan, John Joseph, 83 Willow
1905 Engelke, Charles, 24 Central ave.
1922 Fabricant, Samuel Elmer, 9 Cooke
1937 Finkelstein, William, 103 N. Main
1926 Finn, Alfred Joseph, 164 W. Main
1926 Fitzpatrick, Edward Earl, 83 E. Main
1927 Foster, John Hess, 77 N. Main
1928 Freiheit, John Martin, 85 Grove
1937 Fruin, John William, 76 Center
1909 Gancher, Jacob, 275 N. Main
1923 Godfrey, Edward John, 135 W. Main
1914 Good, William Murray, 63 Center
1894 Goodenough, Edward Winchester, City Hall
1940 Goodrich, William Albert, 138 Grove
1915 Green, Jacques Henry, 171 N. Main
1923 Hackett, John Francis, 154 Grand
1933 Harvey, Joseph LeRoy, 222 Ledgeside ave.
1911 Herr, Edward Albert, 43 Central ave.
1930 Herrmann, Albert Edward, 101 N. Main
1931 Hetzel, Joseph Linn, 103 N. Main
1934 Hill, Frank Joseph, 863 Bank
1939 Hinchey, Richard James, 31 Leavenworth
1919 Jackson, Andrew Joseph, 20 E. Main
1929 Jackson, Edward Joseph, 76 Center
1939 Jennes, Sidney Weinberg, 29 Leavenworth
1922 Johnson, Arthur August, 59 Central ave.
1915 Johnston, Ernest Hillock, 18 Savings
1914 Kirschbaum, Edward Harry, 20 Grove
1940 LaBrecque, Frederick C., 164 W. Main
1922 Larkin, Charles Lewis, 101 N. Main
1910 Lawlor, Michael Joseph, 158 N. Main
1907 Leonard, George Arthur, 79 N. Main
1924 Lombardi, Pasquale Frederick, 46 Prospect
1939 Margolius, Norman Calvin, 125 Grove
1930 Mason, Broadstreet Henry, Waterbury Hosp.
1916 McGrath, John Henry, 309 E. Main
1906 McLarney, Thomas Joseph, 27 Cherry
1925 Merriman, Merritt Heminway, 115 Prospect
1897 Moriarity, James Ligouri, 52 Holmes ave.
1928 Morrill, Harold Frost, 300 W. Main
1928 Mueller, Richard Albert, 287 N. Main
1932 Mullen, John Joseph, 135 W. Main
1929 Neuswanger, Chris Harold, 89 N. Main
1923 Platt, Irving Smith, 77 N. Main
1901 Pomeroy, Nelson Asa, 96 Hillside ave
1940 Post, Edward Andrew, 135 W. Main
1931 Pyle, Edwin, 95 N. Main
1916 Quinn, Raymond James, 730 Baldwin
1939 Reynolds, Joseph A., 95 N. Main
1920 Root, James Harold, 103 N. Main
1925 Ruby, Max Harold, 47 Prospect
1939 Ruby, Robert J., 47 Prospect
1914 Ryder, Raymond Harrison, 52 Central ave.
1931 Sanduli, Gaetano Renato, 64 Cooke
1928 Santoro, Grace Marie, 95 N. Main
1939 Sayers, Daniel O'Connell, 278 East
1933 Shea, Vincent Timothy, 20 E. Main
1935 Slavin, Joseph E., 798 E. Main
1906 Smith, Egbert Livingston, 292 W. Main
1929 Smith, Goodrich Truman, 30 W. Main
1915 Spicer, Edmund, 292 W. Main
1931 Staneslow, John Stanislovaitis, 95 N. Main
1924 Stettbacher, Henry John, 28 Prospect
1906 Swenson, Andrew Clay, 43 Central ave.
1916 Vastola, Anthony P., 103 N. Main
1920 Webber, Edwin Russell, 95 N. Main

WEST HAVEN

1929 Appell, Harold Seymour, 354 Campbell ave.
1938 Chasnoff, John Arthur, 328 Main
1935 D'Esopo, Joseph Nicholas, W. W. Winchester Hosp.
1909 Gilmore, Joseph Leo, 336 Main
1904 Kowalewski, Victor Alexander, 597 Campbell ave.
1930 Milano, Nicola Antonio, 271 Elm
1923 O'Connell, William Michael, 295 Main
1915 Rogers, Platt Harrison, 228 Elm
1933 Snavely, Marion Elizabeth, 546 Washington ave.

OUT OF COUNTY

1939 Anderson, Clifford Winthrop, 116 East Elm, Greenwich
1935 Davis, George Breed, Barren County Health Dept., Court House, Glasgow, Kentucky
1931 Dryfus, Milton Leopold, 130 W. 57 st., N.Y.C.
1921 Dunham, Ethel Collins, 3312 N. st., N. W., Washington, D.C.
1937 Eliot Martha May, 1815 45th N.W., Washington D.C.
1923 Garcia, Alphonso G., Moosup
1896 Graves, Frederick George, Bethlehem
1936 Klumpp, Theodore George, Dept. of Agriculture, Food and Drug Admin., Washington, D.C.
1934 Lirot, Stephen Leo Robert, 1017 Baltimore st., Baltimore
1917 Merill, William Truman, 66 Fuller lane, East Milton, Mass.
1938 Mucci, Lawrence Adolf, New Britain General Hospital, New Britain
1929 Russell, Ernest Frederick, Riven Rock, Santa Barbara, Cal.
1891 Skinner, Clarence Edward, Cedar Gate, Darien
1931 Sullivan, Albert Joseph, 3413 Texas ave., S.E. Washington, D.C.
1914 Sweet, Grover Cleveland, Soldiers Home, Noroton Heights.
1900 Teele, Julia Ernestine, Box 31, Hall-Brooke San., Greens Farms, Conn.

Total number 517

NEW LONDON COUNTY

President, Clarence G. Thompson, M.D., 257 Main st., Norwich
Vice-President, Hugh F. Lena, M.D., 154 Broad st., New London
Secretary, Carl H. Wies, M.D., 58 Huntington Street, New London
Councilor, George H. Gildersleeve, M.D., 310 Main Street, Norwich

Censors

(One elected annually for a term of three years)

1938 James J. Donohue, M.D., 43 Broadway, Norwich
1939 Richard M. Starr, 45 Huntington Street, New London

1940 Harry E. Higgins, 257 Main Street, New London

Committee on Public Policy and Legislation

(Appointed annually by the President)

Charles J. Satti, M.D., 36 Huntington Street, New London, *Chairman*

Louis M. Allyn, M.D., 22 Library Street, Mystic

Henry A. Archambault, M.D., 2 North Second ave., Taftville

Committee on Medical Ethics and Deportment

(One appointed annually by the President
for a term of 5 years)

Robert R. Agnew, 257 Main st., Norwich
Eric H. Blank, 240 Williams st., New London
Edmund L. Douglass, 188 Thames st., Groton
Thomas Soltz, 26 Main st., New London
John W. Suplicki, 255 Main st., Norwich

Annual Meeting, First Thursday in April
Semi-Annual Meeting, First Thursday in October

COLCHESTER

1935 Friedman, Irving, 16 Norwich ave.
1921 Pendleton, Cyrus Edmund, 13 Main

EAST LYME

NIANTIC

1906 Atkinson, Edward, Main
1934 MacLeod, Edith Alice, State Farm for Women
1936 Ward, Lawrence Shapiro

GRISWOLD

JEWETT CITY

1937 Ansell, Harvey Berle, 30 N. Main
1937 Barry, Joseph Charles
1916 McLaughlin, John Henry, 37 Main
1934 O'Neil, Martin Leo, 8 Park sq.

GROTON

1916 Barnum, Charles Gardner, 230 Thames
1918 Douglass, Edmund Latham, 188 Thames
1934 Hewes, Carlisle Tyson, 242 Thames

NOANK

1928 Hill, E. Roland

LYME

1927 Ely, Julian Griffin, R.F.D. No. 2

HADLYME

1924 Raynolds, Randolph

MONTVILLE

UNCASVILLE

1936 Lubchansky, Jacob Harris
1929 Rasmussen, Hans Norman

NEW LONDON

1933 Baron, Shirley Harold, 309 State
1933 Becker, Joseph, 325 State
1928 Blank, Eric Henry, 240 Williams
1940 Brahms, Sigmund Arnold, 563 Ocean ave.
1933 Brosnan, John Francis, 34 Huntington
1927 Burdsall, Elijah Sylvester, 187 Williams
1916 Cheney, George Philip, 179 Montauk ave.
1936 Comstock, Edward Richard, 106 State
1938 DeAngelis, Louis, 252 Montauk ave.
1909 Dunn, Frank Martin, 26 Broad
1931 Dyer, Charles Edward, 102 Montauk ave.
1936 Ferguson, Helen Knox, 508 Montauk ave.
1906 Ganey, Joseph Matthew, 205 Williams
1934 Gipstein, Edward, 58 Huntington
1939 Hartman, Frederick Bittinger, 58 Huntington
1922 Hendel, Isidor, 50 State
1902 Henkle, Emmanuel Alex, 51 Federal
1934 Henkle, Robert Theodore, 51 Federal
1895 Heyer, Harold Hankinson, 70 Coit
1936 Itzkowitz, Hyman, 325 State
1921 Kaufman, Charles, 308 State
1940 Krinsky, Charles Morris, 325 State
1924 Labensky, Alfred, 85 Federal
1909 Lawson, Stuart Johnston, 116 Federal
1921 Lena, Hugh Francis, 154 Broad
1931 Loiacono, Anthony Joseph, 325 State
1939 Moran, James P., 52 Huntington
1934 Morse, Willard Jackson, 32 Channing
1921 Murray, Thomas J., 34 Huntington
1932 Rabinovitch, Alec., 309 State
1936 Rapp, Albert Grant, 325 State
1940 Sabloff, Jack, 325 State
1929 Satti, Charles John, 36 Huntington
1933 Scoville, Dorothea Haven, 40 Channing
1938 Smilgin, Victor Edward, 807 Main
1921 Soltz, Thomas, 26 Main
1929 Starr, Richard Mallory, 45 Huntington
1904 Sullivan, Daniel, 58 Huntington
1940 Sulman, Morris, 203 Montauk ave.
1899 Taylor, John Clifton, 159 State
1933 Taylor, Robert Nelson, 159 State
1925 Warren, Hill Freeman, 100 State
1922 Wellington, Harold Wentworth, 309 State
1935 Wies, Carl Hendricks, 58 Huntington
1913 Wilson, Frank Emery, 302 State
1920 Woodruff, Thomas Adams, 44 Mott ave.
1938 Woodward, Joseph Cutler, 41 Huntington

NORWICH

1910 Agnew, Robert Robertson, 257 Main
1908 Brophy, Edward Joseph, 10 Shetucket
1916 Callahan, John William, 308 Main
1915 Campbell, Hugh Baird, "Uncas-on-Thames."
1935 Carr, Vandeveer Tabor, State Hospital
1934 Carson, Robert James, State Hospital
1925 Dixon, Henry Campbell, 16 Franklin
1897 Donohue, James Joseph, 43 Broadway
1916 Driscoll, William Thomas, 257 Main
1916 Freeman, Albert Clark, 54 Broadway
1898 Gildersleeve, Charles Child, 310 Main
1927 Gildersleeve, George Harold, 310 Main
1935 Hale, Virginia Anne, State Hospital
1935 Higgins, Harold William, 257 Main
1898 Higgins, Harry Eugene, 257 Main
1938 Kettle, Ronald Harry, Norwich State Hospital
1914 LaPierre, Arnaud Julian, 287 Main
1935 Lukoski, Walter Anthony Francis, 16 Franklin
1936 Mahoney, Joseph John, 55 Main
1922 Manwaring, Ier Jay, Disco bldg.
1922 Markoff, Kopland Karl, 16 Franklin
1937 Moore, Maurice R., Laurel Hill rd. R. No. 6
1935 Neumann, Virgil Frank, "Uncas-on-Thames"
1935 O'Connell, Patrick Henry, 10 Shetucket
1933 Ogden, Arthur White, State Hospital
1936 Osgood, Charles, 257 Main
1934 Quintiliani, Albert, 43 Broadway
1930 Raymer, John George, 40 Shetucket
1930 Ricksher, Charles, State Hospital

1935 Sears, Lewis, 257 Main
1938 Segal, Solam, 257 Main
1929 Suplicki, John William, 255 Main
1921 Sussler, David, 65 Main
1925 Thompson, Clarence George, 257 Main
1938 Tombari, Seraphino Paul, 317 Main
1931 Urquhart, Robert Glen, "Uncas-on-Thames."
1935 Weidman, William Harold, "Uncas-on-Thames"
1932 Wener, William Victor, 130 Main

TAFTVILLE

1933 Archambault, Henry Allard, 2 N. Second ave.
1935 Bergendahl, Harold Andrew, 1 S. Second ave.

OLD LYME

BLACK HALL

1909 Devitt. Ellis King

STONINGTON

1934 Haliday, Earle George, 168 Water
1934 Veal, William Thomas, 99 Water
1912 *Williams, Charles Mallory, 174 Water

MYSTIC

1907 Allyn, Louis Maxson, 22 Library
1894 Gray, William Henry, 27 Willow
1932 Leon, A. Joseph, 21 E. Main
1915 Maine, Thurman Park, 64 Washington

WATERFORD

1913 O'Brien, John Francis, "The Seaside."
1931 Thompson, Lawrence Everett, "The Seaside."

OUT OF COUNTY

1932 Griswold, Matthew, 154 Armory st., New Haven
1907 Harrington, James Leon, 15 Eames ave., Amherst, Mass.
1937 Lund, Frederick Albert, Brooklyn Hosp., DeKalb ave. and Ashland pl., Brooklyn, N.Y.
1934 Morse, Lyman Rogers, "Cedarcrest" Hartford
1934 Waterman, Chester, Bartlett st., Portland
1933 Whitty, Charles Aloysius, "Cedarcrest", Hartford

Total number 118

TOLLAND COUNTY

President, WILLIAM SCHNEIDER, M.D., 34 Union Street, Rockville
Vice-President, WALTER C. HAVILAND, M.D., Mansfield State Training School and Hospital, Mansfield Depot
Secretary, FRANCIS H. BURKE, M.D., 27 Park Street, Rockville
Councilor, CHARLES T. LAMOURE, M.D., Mansfield State Training School and Hospital, Mansfield Depot

Censors

(One elected annually for a term of three years)

ELLIOTT H. METCALF, M.D., 50 Elm Street, Rockville
RALPH B. THAYER, M.D., Main Street, Somers
FRANK B. CONVERSE, M.D., West Willington

Committee on Public Policy and Legislation

(Appointed annually by the President)

FRANCIS H. BURKE, M.D., 27 Park Street, Rockville, *Chairman*
ROY C. FERGUSON, M.D., 57 Union Street, Rockville
ALFRED SCHIAVETTI, M.D., 107 Main Street, Stafford Springs

Committee on Medical Ethics and Deportment

(Councilor and one appointed annually by the President for a term of five years)

CHARLES T. LAMOURE, M.D., Mansfield State Training School, Mansfield Depot, *Councilor*
ELLIOTT H. METCALF, M.D., 50 Elm Street, Rockville, *Chairman*
FRANCIS MCL. DICKINSON, M.D., 38 Elm Street, Rockville
FRANK B. CONVERSE, M.D., West Willington
JOHN P. HANLEY, M.D., 15 Church Street, Stafford Springs
JOHN E. FLAHERTY, 42 Elm Street, Rockville
FRANCIS H. BURKE, M.D., 27 Park Street, Rockville, *Recorder*

Annual Meeting, Third Tuesday in April
Semi-Annual Meeting Third Tuesday in October

COVENTRY

SOUTH COVENTRY

1891 Higgins, William Lincoln

ELLINGTON

1940 Levine, Leonard Warren

MANSFIELD

MANSFIELD DEPOT

1934 Clow, Henry Leon, State Training School and Hospital
1930 Hankins, Melissa Millner, State Training School and Hospital
1935 Haviland, Walter Childs, State Training School and Hospital
1918 LaMoure, Charles TenEyck, State Training School and Hospital
1940 Leonard, Robert J., State Training School and Hosp.

SOMERS

1921 Thayer, Ralph Bruce, Main

STAFFORD

STAFFORD SPRINGS

1908 Hanley, John Patrick, 15 Church
1921 Moore, Harry, 46 E. Main
1935 Schiavetti, Alfred, 107 Main

VERNON

ROCKVILLE

1937 Beckwith, Donald Macfarlane, 68 Prospect
1933 Burke, Francis Henry, 27 Park
1908 Dickinson, Francis McLean, 38 Elm
1923 Ferguson, Roy Cameron, 57 Union
1918 Flaherty, John Edward, 42 Elm
1921 Metcalf, Elliott Harrison, 50 Elm
1897 O'Loughlin, Thomas Francis, 26 N. Park
1931 Schneider, William, 34 Union

WILLINGTON

WEST WILLINGTON

1928 Converse, Frank Benjamin

OUT OF COUNTY

Total number 23

WINDHAM COUNTY

President, MORTON ARNOLD, 781 Main Street, Willimantic
Vice-President, MORTON H. CHAPNICK, 168 Main Street, Putnam
Clerk, RALPH L. GILMAN, M.D., Storrs, Conn
Councilor, ROBERT C. PAINE, M.D., Thompson

Censors

(One elected annually for a term of three years)

Brae Rafferty, M.D., 807 Main Street, Willimantic
Fred M. Smith, 736 Main Street, Willimantic
Ernest R. Pike, East Woodstock

Committee on Public Policy and Legislation

(Elected annually)

Robert C. Paine, *Chairman*, Thompson
Florence F. Dean, 32 So. Main Street, Putnam
George E. Roch, 33 Church Street, Willimantic

Committee on Medical Ethics and Deportment

(Two appointed annually by the President
for a term of three years)

Board of Censors: *The President, The Clerk*

Committee on Medical Economics

Gerard M. Chartier, M.D., 136 Main Street, Danielson
Joseph A. LaPalme, M.D., 158 Main Street, Putnam
Karl T. Phillips, 66 Main Street, Putnam

Annual Meeting, Third Thursday in April
Semi-Annual Meeting, Third Thursday in October

CANTERBURY

1936 Baldwin, Helen

HAMPTON

1914 Marsh, Arthur Drought

KILLINGLY

Danielson

1935 Chartier, Gerard Marcel, 136 Main
1928 Garcin, Cecil Redvers, 7 Broad
1938 Lambert, George S., 41 Broad
1909 Perreault, Joseph Napoleon, 43 Main
1919 Tanner, Warren Avery, 36 Academy
1920 Todd, Frank Paige, 178 Main

MOOSUP

1940 Couture, Arthur Joseph, 19 S. Main

PLAINFIELD

1903 Chase, Arthur Alverdo, Railroad ave.
1933 Gulino, Angelo James

Pomfret Center

1937 Geck, Otto Francis

PUTNAM

1934 Chapnick, Morton Herman, 168 Main
1930 Dean, Florence Franklin, 32 S. Main
1927 LaPalme, Joseph Antonio, 158 Main
1919 Murphy, Bernard Patrick, 205 Main
1921 Phillips, Karl Tristram, 66 Main
1922 Russell, John Jarvis, Bridge and Main
1934 Shepard, William Mac. 66 Main

THOMPSON

1903 Paine, Robert Child

NORTH GROSVERNORDALE

1936 Roy, Joseph Lambert

WINDHAM

Willimantic

1935 Arnold, Morton, 781 Main
1939 Basden, Edward Herbert, 199 Church
1939 Carter, George Howard, 29 North
1901 Girouard, Joseph Arthur, 19 Union
1896 Hills, Laura Heath, 727 Main
1913 Jenkins, Charles Albert, 715 Main
1928 Kinney, Kenneth Kyle, 29 North
1925 Ottenheimer, Edward Joseph, 29 North
1932 Rafferty, Brae, 807 Main
1916 Riordan, Michael Davitt, 29 North
1936 Roch, George Emile, 33 Church
1937 Rothblatt, Reuben, 672 Main
1914 Shea, Richard Edward, 850 Main
1914 Smith, Fred Morse, 736 Main
1935 Vernon, Sidney, 828 Main

WOODSTOCK

East Woodstock

1913 Pike, Ernest Reginald

OUT OF COUNTY

1910 Downing, Francis, 287 Main st., Norwich
1883 Foster, Warren Woden, 4000 Cathedral ave., Washington, D.C.
1932 Gilman, Ralph Lawrence, Storrs
1929 Spector, Nathan, 60 Broad St., Lynn, Mass.

Total number 39

SUMMARY

Fairfield County	379
Hartford County	532
Litchfield County	78
Middlesex County	70
New Haven County	517
New London County	118
Tolland County	23
Windham County	39
Total	1756

Alphabetical Roll of Members

With date and place of graduation.

Aaronson, M.S., Univ. & Bellevue, '13, Ansonia
Abbey, E.A., B.A., Mt. St. Mary's, '26, Georgetown, '30, New Haven
Abrahams, M., Tufts, '31, New Canaan
Abrashkin, M.D., Maryland, '32, New Haven
Adam, F.S., Ph.B., Boston U., '21 Yale, '25, No. Canaan
Adzima, J. M., Univ., Md., '27, Bridgeport
Affinito, T., B.S., Yale, '26, McGill, '31, Meriden
Agnew, R.R., Yale, '08, Norwich
Aiken, S., Toronto U., '29, Manchester
Alderman, I. S., Ph.B., Yale, P & S., N.Y., '19, New Haven
Allen, E. P., B.A., Lebanon Valley (Pa.) Coll., '20, Yale, '24, New Haven
Allen, H.E., B.A., Bowdoin, '15, Bowdoin, '19, Waterbury
Allen, H. S., Yale, '04, Woodbury
Allen, M.F., Med. Chi., Phila., '95, New Haven
Allen, W.M., B.A., Haverford, 16, Johns Hopkins, '20, Hartford
Alling, A. N., B.A., Yale, '86, P. & S., N.Y., '91, New Haven
Allyn, L. M., Univ. Pa., '03, Mystic
Alpert, M., B.S., Yale, Yale, '28, Bridgeport
Alpert, R.H., Yale '13, New Haven
Alu, A. F., Yale, '20, Ansonia
Amatruda, F. G., B.A., Yale, '20, Yale, '23, New Haven
Amos, I.L., McGill, '26, Danbury
Amoss, H. L., BS., Univ., Ky., '05; M.S., Univ. Ky., '07; D.P.H., Harvard, '12; Sc.D. (Hon) Geo. Wash., '22, Harvard, '11 Greenwich
Anderson, C. W., A.B., Colgate, '30, Harvard, '34, Greenwich (New Haven Co.)
Andrus, O. B., B.A., Dartmouth, '28, Univ. & Bellevue, '32, Devon
Andrews, E. M., Univ. Maine, '25; Harvard, '30, Hartford
Angus, L.R., B.A., Toronto, '25, Toronto U., '28, Hartford
Ansell, H. B., Tufts, '32, Jewett City
Antell, M. J., B.S., Middlebury, '25, Univ. Vt., '29, Bridgeport
Antupit, L., B.S., Trinity, '19, Jefferson, '23, Hartford
Appell, H.S., Tufts, '27, West Haven
Appell, P.H., Univ., & Bellevue, '23, Bristol
Apsel, A., Ph.G., Brooklyn Coll. Phar., '13, L. I. Coll. Hosp., '18 Bridgeport
Apter, H., B.A., Geo. Wash., '31, Geo. Wash., '34, Hartford
Archambault, H. A., Tufts, '27, Taftville
Arnold, H. B., B.A., Yale, '23, Yale, '26, New Haven
Arnold, H. S., B.A., Yale, '00, Yale, '03, New Haven
Arnold, M., B.A., Harvard, '25, Harvard, '29, Willimantic
Arons, M. R., Ph.B., Yale, '25, Univ. Md., '30, Hartford
Ashcroft, A. D., P. & S. Coll., '35, Stratford
Ashley, H. C., Univ. Va., '26, New Hartford
Atha, H. G., Ph. B., Brown U., '27, Tufts, '34, Thomaston
Atkins, S. M., Tufts, '22, Waterbury
Atkinson, E., Univ. Vt., '93, Niantic
Audet, C. H., Univ. Md., '17, Waterbury
Austin, A. E., B.A., Amherst, M.A., Amherst, '04, Jefferson, '05, Old Greenwich
Awdziewicz, F. J., B.S., Yale, '29, Yale, '32, Stamford
Ayres, P.B., Toronto '32, Cos Cob
Backer, M., Yale, '24, Bridgeport
Backus, H. S., L. I. Coll. Hosp., '03, Hartford
Bailey, H., B.A., Yale, '19, Univ. Md., '22, Hartford
Bailey, N. H., P. & S., Balt., '11, Hartford
Baker, P. G., B.S., Univ. Vermont, '30, Univ. Vermont, '33, Winsted
Bakunim, M. I., B.S., Yale, '28, Jeff., '32, Bridgeport
Baldwin, C. T., Bellevue, '83, Derby
Baldwin, H., B.A., Wellesley, '88, Wom. Med., N.Y., '92, Canterbury
Baldwin, W. P., B.A., Yale, '88, Yale, '90, N.Y. Homeo., '91, New Haven
Balletto, V., B.S., Yale, '29, Tufts '33, East Haven
Bancroft, H.A., Albany Med., '16, Hartford
Banks, D. T., Fordham, '12, Bridgeport
Bannon, F. M., Univ. Vt., '28, Stamford
Barald, F. C., B.S., Univ. of Conn. '32, Boston Univ. '36, New Haven
Barber, W. L., Jr., B.A., Yale, '03, Univ. & Bellevue, '07, Waterbury
Barker, A. J., Bellevue, '97, Torrington
Barker, C., Dartmouth, '13, New Haven
Barker, N. J., Univ. of Toronto, '26, Hartford
Barnes, F. H., N. Y. Homeo, '96, Stamford
Barnes, W. S., Ph.B., Yale, 95, Yale, '97, New Haven
Barney, W. E., B.S., Catholic U., '31, Yale '35, Milford
Barnum, C. G., B.A., Middlebury Coll., '05; M.A., Middlebury Coll., '07, Yale, '11, Groton
Baron, S. H., Cornell, '27, New London
Barrett, W. J., Md. Med., '04, New Haven
Barry, J. C., Boston U., '33, Jewett City
Barstow, R.I., B.A., Union Coll., '29, Jeff., '33, Norfolk
Bartlett, C. J., B.A., Yale, '92; M.A., Yale, '94, '95, New Haven
Basden, E.H., Tufts, '33, Willimantic
Bassin, A. L. Rochester, '30, New Haven
Batelli, C. F., B.A., Yale, '25, Yale, '28, New Haven
Battista, A. W., Tufts, '24, New Haven
Bausch, C. P., Tufts, '29, Hartford
Bayne-Jones, S., B.A., Yale, '10; M.A., Johns Hopkins, '17, Johns Hopkins, '14, New Haven
Beacb, C. C., PhB., Yale, '77, P. & S., N.Y., '82, Hartford
Beach, C. T., Yale, '05, Hartford
Beatman, I., B.S., Trinity, '23, Tufts, '27, Hartford
Beatrice, A. A., Tufts, '29, Bristol
Beauchemin, J. A., Montreal, U., '25, Middletown
Beaudry, J. H., McGill, '13, Bridgeport
Beck, E. C., Yale, '26, So. Norwalk
Beck, F. G., Yale, '03, New Haven
Becker, J., B.S., N. Y. U., '26, Univ. & Bellevue, '29, New London
Beckwith, D. M., A.B., Johns Hopkins, '28, Harvard, '34, Rockville
Behan, E. J., McGill, '22, New Haven
Beizer, E., B.A., Harvard, '25, L.I. Coll. Hosp., '30, Hartford
Bell, J. S., Illinois, '28, Ridgefield
Benedict, M. K., Johns Hopkins, '19, New Haven
Benoit, R. J., Georgetown, '26, New Britain
Bergendahl, H. A., Tufts, '33, Taftville
Bergin, T. J., Yale, '99, Cos Cob
Bergman, A., B.S., Stockholm, '89, U. City N.Y., '95, New Haven
Berlowe, M. L.,B.S., Univ. of Georgia, '30, L.I. Coll. Med. '34, New Haven
Berman, B.A., Tufts, '34, Waterbury
Berman, H.L., B.A., Yale, '13, Yale, '15, New Haven
Bernstein, A., Yale, '08, Bridgeport
Bernstein, D. J., B.S., Univ. Vt., '30, Univ. Vt., '33, New Britain
Bestor, E. L. N. Y. Homeo., '07, Hartford
Bevans, T. F., Univ. Minn., '03, Waterbury
Bidgood, C. Y., B.S., Univ. Va., '19, Univ. Va., '20, Hartford
Biehn, D. M. F., Queen's Univ. Canada, '37, Fairfield
Biehn, S. L., B.S., Toronto U., '26, Fairfield
Bienkowski, J. G., B.S., Trinity, '30, Howard, '35, Torrington
Bill, P. W., PhB., Yale, '97; P. & S. N.Y., '01, Westport
Bingham, C.T., B.A., Yale, '28, P. & S., N.Y., '32, Hartford
Biram, J. H., Cornell, '10, Hartford
Bird, F. S., B.S., Univ. Vt., '30, Univ. Vt., '33, Bristol
Birdsong, J. L., B.S., Nashville U., '99, Johns Hopkins, '09, Hartford
Birge, H. L., Dartmouth, '30, Penn., '33, Hartford
Bishop, C. C., Yale, '30, New Haven
Bissell, A. H., Litt. B., Princeton, '12, Cornell, '16, Stamford
Bizzozero, O. J., B.S., Univ. Vt., '24, Univ. Vt., '27, Waterbury
Blair, E. H., P. & S., Balt., '06, Hartford
Blake, E. M., Yale,, '06, New Haven
Blake, F. G., B.A., Dartmouth, '08, Harvard, '13, New Haven

Blanchard, D. L., B.S., Bowdoin, '27, Yale, '25, Branford
Blank, E. F., Starling, '97, Bridgeport
Blank, E. H., Univ. Vt., '25, New London
Blodinger, I. E., PhB., Yale, '22, Yale, '25, New Haven
Blogoslawski, W. J., Georgetown, '27, New Britain
Bloom, D. I., Conn. State, '30, Tufts, '35, Thompsonville
Blumenthal, E. J., B.S., Yale, '28, L. I., Coll., '32, Ansonia
Blumer, G., M.A., Yale, '07, Cooper, '91, New Haven
Boardman, A. K., Univ. Pa., '99, New Haven
Boardman, E. I., B.A., Smith, '15, Cornell, '20, New Haven
Bodie, J. A., Tufts, '24, New Haven
Bodie, W. J., Georgetown, '29, Branford
Bodley, G. H., Yale, '07, New Britain
Bogin, M., B.S., Yale, '23, Yale, '26, Bridgeport
Boisvert, P. L., B.S., Hobart, '30, Rochester, '34, New Haven
Bonner, R. A., Univ. of Maryland, '12, Waterbury
Bonoff, Z. A., Yale, '04, New Haven
Booe, J. G., B.A., '16, B.S., '17, Wake Forest Coll. N.C., Med. Coll. Va., '19, Bridgeport
Booth, J. D., B.S., Dartmouth, P. & S., N.Y., '26, Danbury
Borkowski, B. J., Georgetown, '28, Bristol
Botsford, C. P., Yale, '94, Hartford
Bowman, S. H., Hahn, Chicago, '13, Stamford
Boyarsky, H. M., B.S., Tufts, '28, Tufts, '31, Wallingford
Boyd, H., B.S., Allegheny Coll., '15, Harvard, '21, South Manchester
Brackett, A. S., B.A., Yale, '92, Jefferson, '95, Bristol
Bradeen, F. B., Univ. Pa., '99, Essex
Bradley, T. R., Univ. Md., '14, South Norwalk
Brahms, S. A., New York Univ., '35, New London
Brainard, C. B., PhB., Yale, '94, Yale, '98, Hartford
Branon, A. W., Jefferson, '13, Hartford
Brayton, H. W., PhB., Brown, '06, Harvard, '11, Hartford
Breck, C. A., Ph,B., Yale, '26, Yale, '30, Wallingford
Brecker, F. W., Tufts, '28, East Hartford
Brennan, E. L., Univ. of Ireland, '23, Hartford
Brennan, P. J., Yale, '07, Waterbury
Bretzfelder, K. B., Jefferson, '16, New Haven
Brewer, F., A.B., Oberlin, Columbia, '20, Brookfield Center
Brewer, T. F., Yale, '26, Hartford
Bria, W. F., Univ. of Rome, '34, Stamford
Bridge, J. L., B.S., Wesleyan, '88; PhD., Clark, '94, Harvard, '03 Hazardville
Bristoll, D. A., B.A., Hamilton, '23, Univ. Pa., '27, New Britain
Brodsky, M. E., B.A., Clark, '19, Northwestern, '26, Bridgeport
Brody, B. S., B.A., Yale, '25, Yale, '28, New Haven
Bronson, W. T., N. Y. U., '98, Danbury
Brooks, P. L., McGill, '32, Bridgeport
Brophy, E. J., Yale, '04, Norwich
Brosnan, J. F., Tufts, '30, New London
Brown, A. S., B.A., Yale, '23, Yale, 26, Waterbury
Brown, C. H., U. City N.Y., '93, Waterbury
Brown, D. C., Yale, '84, Danbury
Brown, P. H., Univ. Vt., '26, Stamford
Bruckner, W. J., B.S., N. Y. Univ., '29, Cornell, '33 New Haven
Bruyere, P. T., B.A., Princeton, '30, Univ. Chicago, '34 Kent
Buccheri, F. S., Tufts, '32, Tufts, '35, New Britain
Bucciarelli, J. A., Temple, '31, New Canaan
Buck, B. J., B.A., Colgate, '22, Harvard, '26, Hartford
Buckhout, G. A., Tufts, '35, Bridgeport
Buckley, R. C., B.S., Trinity, '20, Yale, '24, Hartford
Buckley, J. W., Georgetown, '33 Bridgeport
Buckmiller, F. C., Univ. Vt., '14, Bridgeport
Budau, J. H. D., Yale, '00, Milford
Buffum, J. H., Ph.B., Univ. Vt., '96, Univ. Vt., '98, Wallingford
Bull, J. N., P. & S., N. Y., '78, Plainville
Bumstead, J. H., B.A., Yale, '19, Johns Hopkins, '23, New Haven
Bunnell, W. W., B.S., Lafayette, '25, Yale, '29, Farmington
Buol, R. S., B.S., Univ. Mich., '21, Harvard, '23, New Britain
Burdsall, E. S., Hahn, Phila., '11, New London
Burgdorf, A. L., B.S., Chicago, '27, Rush, '31, Bloomfield
Burke, F. H., B.S., Georgetown, '29, Georgetown, '31, Rockville
Burke, J. F., B.A., Holy Cross, '27, Yale, '31, Waterbury
Burlingame, C. C., Hahn, Chicago, '08, Hartford
Burns, G. D., Yale, '25, Derby
Burns, M., M.B., B.A., Univ. Texas, '23, Univ. Texas, '27, Hartford
Burr, N. A., Yale, '01, Higganum
Butler, N. G., Tufts, '24, Hartford
Byren, D. W., B.A., Wesleyan, '23, P. & S., N.Y., '27, Hartford
Caldwell, D. M., McGill, '19, South Manchester
Calhoun, H. A., B.S., Colby, '30, Tufts, '34, Middletown
Callahan, J. W., P. & S., Balt., '11, Norwich
Calverley, E. J., T. Wom, Med., Pa., '08, Hartford
Calvin, C. V., Harvard, '16, Bridgeport
Cammaun, D. DeN., Ph.B., Yale, Columbia, '33, New Canaan
Campbell, H. B., Univ. Pa., '09, Norwich
Campbell, S., Univ. Vt., '23, Meriden
Canfield, N. B.S., Dartmouth, '25, Univ. Mich., '29, New Haven
Cantarow, D., Tufts, '11, Hartford
Capecelatro, A., Tufts, '19, New Haven
Caplan, H., Yale, '27, Meriden
Caplan, M., B.S., Yale, '26, Louisville, '33, Meriden
Cappiello, S., Tufts, '19, Hartford
Carelli, G. F., Yale, '11, New Haven
Carey, T. C., B.S., Trinity, '24, Yale, '28, Hartford
Carey, W. C. Columbia, '33, Meriden
Carlin, C. H., Univ. Mich., '96, Torrington
Carnigila, E. F., B.A., Harvard, '25, Harvard, '29, Hartford
Carpenter, R. M., Loyola, '16, Stamford
Carr, V. T., Hahn, Chicago, '07, Norwich
Carroll, F. P., B.S., Trinity, '10, Johns Hopkins, '14, Bridgeport
Carroll, J. E., B.S., Colgate, '21, Boston, U., '25, Hartford
Carroll, P. R., Jr., Georgetown, '29, Bridgeport
Carroll, W. E., B.A., Dartmouth, '11, Dartmouth, 14, Meriden
Carrozzella, J. C., B.S., Yale, '24, L.I., Coll. Hosp., 28, Wallingford
Carson, R. J. Toronto Univ., '23, Norwich
Carter, E. B., Ph.B., Yale, '07, Johns Hopkins, '11, Hartford
Carter, G., B.S., B.A., M.A., Johns Hopkins, '28, Greenwich
Carter, G. H., A.B., Amherst, '31, P & S., '35, Willimantic
Carvey, E. V., Yale, '29, Yale, '35, Wethersfield
Carwin, J. L., B.A., Morehouse, '26, Meharry, '32, Stamford
Casagrande, J. J., B.S., Fordham, '27, St. Louis, '32, Ansonia
Case, E. P., Ph.D., Lafayette, '05, Univ. Mich, Homeo., '11, West Hartford
Case-Downer, M., Boston U., '29 Hamden
Castaldo, L. F., Tufts, '37, Bridgeport
Caulfield, E. J., Johns Hopkins, '20, Hartford
Celentano, L. E. H., B.S., Trinity, '24, Hahn, Phila., '30 New Haven
Cenci, V. P., Tufts, '29, Hartford
Chaffee, J. S., Ph.B., Yale, '94, Univ. Pa., '97, Sharon
Chalmers, H. E., Tufts, '06, New Britain
Chapnick, M. H., B.S., M.S., Trinity, Jefferson, '32, Putnam
Chartier, G. M., B.A., Assumption, '29, Boston U., '33, Danielson
Chase, A. A., Harvard, '01, Plainfield
Chase, C. C., Univ. Vt., '24, Middletown
Chasnoff, J. A., B.S., Yale, '31, L.I. Med. Coll., '36, West Haven
Cheney, B. A., B.A., Yale, '88, Yale, '90, New Haven
Cheney, G. P., Md. Med., '13, New London
Cheney, M. L., Univ. Vt., '17, Bridgeport
Chernaik, S. J., Jefferson, '16, New Britain
Childs, A.E., N.Y.U., '96, Litchfield
Chipman, S. S., B.A., Acadia, '24, McGill, '28, Norwalk
Chobian, J. A., A.B., Holy Cross, '29, Loyola, '33, Seymour
Caliborn, L. N., Washington, '27, New Haven
Clark, J. B., P. & S., N.Y., '98, Greenwich
Clark, M. H., Wom. Med., Pa., '33, New Haven
Clarke, C. C., B.A., Yale, '27, Yale, '32, D.M.S., Columbia, '38, New Haven
Clarke, J. A., Bellevue, '97, Greenwich
Clarke, R. deB., B.A., N.Y.U., '04, Johns Hopkins, '08, Hartford
Clarke, W. C., P. & S., N.Y., '99, Cornwall Bridge
Clason, F. P., B.A., Bates, '11, Harvard, '15, Hartford
Cleary, H. J., Tufts, '29, Watertown
Clifford, M. L., B.A., Univ. Colorado, '30, C.P.H., Johns Hopkins, Univ. Colorado, '33, Hartford
Clifton, H. C., Univ. Pa., '01, Hartford
Climan, M., B.A., Yale, P. & S., N.Y., '15, Hartford
Climo, S., Ohio State, '29, New Haven
Close, J. F., B.A., Colgate, '21, P. & S., N.Y., '25, Greenwich
Clow, H. L., Tufts, '14, Mansfield Depot
Coates, S. P., Lehigh, '30, Maryland, '34, Suffield
Cobb, A. E., Yale, '98, Canaan (Hartford Co.)
Cobey, J. F., Ph.B., Yale, '12, Yale, '16, New Haven
Cochran, L. B., Univ. Pa., '93, Hartford
Coffey, J. R., A. B., Yale, '03, Yale, '07, New Haven
Cofrances, L. W., Jefferson, '23, New Haven

Cogan, G. E., B.S., Georgetown, '21, Georgetown, '23 Hartford
Cogland, J. L., Univ., of Vt., '31, Univ. of Vt., Coll. of Med., '34, Hartford
Cognetta, J. J., Univ. of Vt., '36, Stamford
Cogswell, E. S., Harvard, '12, Hartford
Cogswell, L. P., A.B., Univ. Maine, '27, Harvard, '33, Hartford
Cohane, J. J., Yale, '98, New Haven
Cohane, T. F., Yale, '97, New Haven
Cohen, D. J., Yale, '32, Meriden
Cohen, J., B.A., Coll. City N.Y., '94, Eclectic, N.Y., '09, Bridgeport
Cohen, W., Ph.B., Yale, '20, Yale, '23, New Haven
Cohn, S. H., Boston, '30, '34, Hartford
Cole, C. H., Yale, '32, B.S., Lafayette, '27, New Haven
Coleburn, A. B., Ph.G., N.Y. Coll. Pharm., '84, P. & S., N.Y., '90, Norwalk (Middlesex Co.)
Collins, J. O., Baylor, '29, Waterbury
Collins, W. F., Yale, '04, New Haven
Colomb. A. C., B.A., Univ. of Calif., '22, Univ. of Calif., '26, Philadelphia, Pa., (Middlesex Co.)
Colwell, H. S., B.S., Colgate, '10, Johns Hopkins, '14, New Haven
Comfort, C. W., Jr., B.A., Yale, '07, Yale, '11, New Haven
Compson, F. E. M., B.A., Geo. Wash., '19, Boston U., '20, Middletown
Comstock, E. R., B.S., Tufts, 30, Tufts, '33, New London
Conklin, C. S., Fordham, '16, Bridgeport
Conlon, W. L., Jefferson, '36, Ph.B., Providence Coll., '32, Manchester
Connolly, A. J., B.S., Georgetown, '24, Georgetown, '28, New Haven
Connor, J. J., B.S., Trinity, '26, Yale, '30, Hartford
Connor, G. M., Villanova, '31, Boston Univ., '35, Plantsville
Connors, E. R., Boston U., '31, Bridgeport
Conroy, M.J., B.A., Yale, '18, Yale, '20, Meriden
Conte, H. A., L.I., Coll. Hosp., '12, New Haven
Conte, M.G., Providence, '30, Royal Univ., of Naples '35, New Haven
Converse, F. B., Eclectic, Cinn., '94, West Willington
Cook, G. F., Tufts, '23, Plainville
Cook, R. J., B.A., Iowa, '09, Johns Hopkins, '13, New Haven
Cooley, C. M., Yale, '08, New Britain
Coon, W. H., Bellevue, '97, Bridgeport
Corbett, H. J., Tufts, '29, Waterbury
Corcoran, M. A., Tufts, '30, Hartford
Corey, W. VanA., Geo. Wash., '33 Hamden
Cornelio, F. J., B.S., Niagara, '30, Georgetown, '34, Winsted
Cornwell, P.M., B.S., Trinity, Yale, '34, E. Hartford
Corradino, C. L., Tufts., '29, New Haven
Corridon, J. D., B.A., Fordham, '24, Georgetown, '28, So. Norwalk
Costanzo, J. J., Univ. Ill., '05, Stamford
Costanzo, R. E., Loyola, '14, Stamford
Costello, H. N., B.A., Yale, '06, Johns Hopkins, '10, Hartford
Cotterio, T., B.S., Yale, '26, Waterbury
Couch, A. R., B.A., Amherst, '01, N.Y., Homeo., '05, Hartford
Couch, F. H., B.A., Harvard, '27, Yale, '30, Cromwell
Couch, M. W., B.A., Smith, '18, Univ. Minn., '27, Cromwell
Couture, A. J., A.B., Assumption Coll. Boston Univ., '32, Moosup
Cox, R. B., McGill, '02, Collinsville
Coyle, A. E. M., Wom. Med., Pa., '12, Windsor Locks
Coyle, B. J., St. Bonaventure, '11, Georgetown, '18, Windsor Locks
Cragin, D. B., Harvard, '02, Hartford
Craighill, M.D., B.A., B.S., Wisconsin, '20 Johns Hopkins, '24 Greenwich
Craig, G. M., B.S., Wesleyan, '16, Harvard, '20, Middletown
Crane, R. W., Yale, '05, Stamford
Crawley, G. A., Temple, '28, West Hartford
Creadick, A. N., B.A., Univ. Pa., Univ. Pa., '08, New Haven
Creaturo, N. E., B.A., Columbia, '28, Boston U., '31, Bridgeport
Crook, J. B., N.Y., Homeo, '13, East Haddam
Crosby, E. H., B.A., Amherst, '24, Yale, '28, Hartford
Culotta, C. S., B.S., Yale, Yale, '28, New Haven
Cunningham, J. M., B.S., Univ. Texas, '23, Univ. Texas, '26, Hartford
Cunningham, R. D. M., B.S., Tufts, '26, Yale, '30, Stamford
Curley, W. H., Cornell, '08, Bridgeport
Curran, E. R., Jefferson, '24, Union City
Curran, H. J., Tufts, '24, Thomaston
Curran, P. J., P. & S., N.Y., '01, Bridgeport
Curtis, B. H., Columbia, '33, P. & S., '36, N.Y.C., (Hartford Co.)
Cushman, L. A., B.S., Wash. & Lee, '20, Harvard, '24, West Hartford
Cutler, H. S., A.B., Univ. Alabama, '33, St. Louis, '37, New Haven
Daley, L. W., McGill, '30, Med. & Sur, McGill, '30, New Britain
Dallas, M., Boston U., '22, New Haven
Dalton, G. H., Yale, '12, New Britain
Daly, C. W., P. & S., Balt., '10, Hartford
Daly, W. P., B.S., Georgetown, '15, Georgetown, '17, Hartford
D'Ambruoso, D. C., Columbia, '36, Derby
D'Amico, M., B.S., Yale, '28, Yale, '31, New Haven
Damiani, R. A., Tufts, '33, Waterbury
Danaher, T. J., B.S., Yale, '25, Yale, '28, Torrington
D'Andrea, F. H., B.S., Yale, '26, Yale, '29, Stamford
Darrow, D. C., B.S., Cornell, '16, Johns Hopkins, '20, New Haven
Darrow, J. E., Tufts, '28, New Britain
Davenport, A. K. P., Md. Coll., S.C., '03; Syracuse U., '17, Hartford
Davis, C. C., Yale, '07, Essex
Davis, G. B., B.S., Dartmouth, '21, Univ. Vt., '24, Glasgow, Kentucky, (New Haven Co.)
Davis, J. B., Kansas, '33, New Haven
Davis, J. E., B.A., Roanoke Coll., '15, Johns Hopkins, '19, W. Hartford
Dawson, L. M., Queen's, '09, Hartford
Day, F. L., B.A., Bates, '90, Bellevue, '93, Bridgeport
Day, R. S., N.Y. Med. Coll., '06, New Milford
Dayton, A. B., Ph.B., Yale, '11, Johns Hopkins, '15, New Haven
Dean, F. F., B.A., Cornell, '24, Cornell, '28, Putnam
Dean, S.R., U. of Mich., '34, Newtown
DeAngelis, L., B.S., Wesleyan, C.P.H., Yale, A.M. Columbia, Virginia Med., '36, New London
DeBonis, D.A., B.A., Victor Immanuel College, Naples, '84, Univ. Naples, '90, Hartford
de la Vergne, P.M., A.B., Michigan, '30. McGill, '35, Meriden
Delohery, C. L., Ph.B., Villanova, Temple, '26, Danbury
DeLuca. H. R., Geo, Wash., '16, Bridgeport
DelVecchio, L. F., Georgetown, '31, Bridgeport
Deming, C.D., B.A., Yale, '07, Johns Hopkins, '10, Hartford
Deming, C. K., P. & S., N.Y., '17, New Haven
Deming, C. L., B.A., Bowdoin, '10, Yale, '15, New Haven
Deming, D. B., P. & S., N.Y., '01, Waterbury
Deming, E. A., Ph.B., Yale, '04, Johns Hopkins, '08, Hartford
Denne, T. H., Univ. Vt., '05, West Hartford
Dennehy, W. J., B.A., Yale, '15, Yale, '18, New Haven
DePasquale, F. L., Univ. Pa., '26, Hartford
DePasquale, J. A., Catholic Univ., '32, Univ. Penn., '36, Hartford
DeRosa, S. F., Jefferson, '24, Meriden
Derwin, J. J., B.S., St. Bonaventure, Georgetown, '30 Winsted
Desmond, W. F., B.A., Univ. Mich., '21, Yale, '25, Newtown
D'Espo, J. N., B.S., Trinity, '26, McGill, '31, West Haven
DeVito, M. J., Vanderbilt, '28, Hartford
Devitt, E. K., Md., '07, Old Lyme
DeWitt, E. N., Univ. Pa., '17, Bridgeport
Diamond, E. H., B.S., Yale, 28, Univ. Beslau, '32, Springdale
Dichter, C. L., Md. Med., '05, Stamford
Dichter, I. S., B.A., Columbia, '27, Jefferson, '31, Stamford
Dickinson, F. McL., Ph.B., Yale, '00, P. & S., N.Y., '05, Rockville
Diefendorf, A. R., B.A., Yale, '94, Yale, '96, New Haven
DiFrancesco, L. P., Tufts, '31, Stamford
Dignam, B. S., B.A., Trinity, '30, Yale, '35, Thompsonville
Dignam, E. A., Med. Coll. Va., '28, Hartford
Dillon, J. H., Yale, '04, Waterbury
Dinsmore, W. W., B.S., Univ. Ala. Poly. Inst., Johns Hopkins, '07 Hartford
Dion, A. J., Tufts, '28, Hartford
Dixon, H. C., B.A., Bowdoin, '14, Bowdoin, '17, Norwich
Dobbs, W. G. H., A.B., Rochester, '31, Rochester, '34, New Haven
Dodd, B., P. & S., '33, B.S., Yale, '29, Hartford
Dominick, D., Yale, '34, Bridgeport
Donnelly, S. P., Georgetown, '24, New Britain
Donner, S., B.A., Yale, '18, Cornell, '33, Hartford
Donohue, B. F., Yale, '03, Bristol
Donohue, J. J., P. & S., Baltimore, '96, Norwich
Donovan, W. F., B.S., Conn. S., '26, Boston U., '31, Hartford
Dorion, R. H., Vermont, '32, Stamford
Douglass, E. L., L. I., Coll. Hosp., '16, Groton
Dowd, M. J., Balt. Med., '01, Thompsonville
Downing, F., Balt., Med., '08, Norwich (Windham Co.)
Dray, E. J., Jefferson, '09, New Britain
Dreher, A. C., Yale, '23, Waterbury
Driscoll, J. J., Univ. Vt., '25, Danbury
Driscoll, W. T., P. & S., Balt. '12, Norwich
Dryfus, M. L., Yale, '12, New York City (New Haven Co.)
DuBois, F. S., A.B., Wabash, '26, M.S., Univ. Chicago, '28, Rush, '31 New Milford
Dudac, T. W., B.S.M., Georgetown, '31, Georgetown, '33, Southington

Duffy, L. T., B.S., Conn. St., '30, Tufts, '34, Hartford
Duffy, V. P., Univ. Md., '17, Naugatuck
Duffy, W. C., B.A., Wake Forrest, '10, Johns Hopkins, '14, New Haven
Dunham, E. C., B.A., Bryn Mawr, Johns Hopkins, '18, Washington D.C. (New Haven Co.)
Dunn, F. M., Balt. Med., '08, New London
Dunn, G. W., Balt. Med., '09, New Britain
Dunne, E. P., Holy Cross, '12, Univ. Maryland, '18, Unionville
Dunne, R. E., B.A., Catholic Univ., Harvard, '19, Hartford
Durkee, R. E., Jr., Harvard, '29, Harvard, '36, Hartford
Dwyer, P. J., B.A., Fordham, '04, N.Y.U., '97, Waterbury
Dwyer, W., B.S., Trinity, '09, Johns Hopkins, '13, Hartford
Dye, J. S., B.A., Vanderbilt, '00, P. & S., N.Y., '15, Waterbury
Dyer, C. E., Tufts, '28, New London
Earle, B. B., B.A., Baylor, '25, Rush, '30, Glastonbury
Eckert, G. R., Tufts, '33, Danbury
Edgar, K. J., B.A., Oregon, Oregon, '31, Bridgeport
Edlin, C., Tufts, '25, Waterbury
Edson, R. H., Cornell, '35, B.S., Princeton, Shelton
Egan, J. J., Univ. Md., '07, Waterbury
Egee, J. B., B.S., Hahne, '30, Hahne, '34, Sandy Hook
Eimas, A., Tufts, '30, Bridgeport
Eliot, M. M., Johns Hopkins, '18, Washington, D.C. (New Haven Co.)
Elliot, K. G., Tufts, '26, Hartford
Elliott, G. A., Toronto, U., '24, Middletown
Elliott, J. R., B.A., Holy Cross, '28, Boston U., '32, Canaan
Ellis, F. D., Jr., B.A., Univ. Pa., '15, Univ. Pa., '18, Farmington
Ellison, F. S., Hamilton, '30, Yale, '34, Hartford
Ellrich, D. L., B.A., Harvard, 24, Jefferson, '28, Westport
Elmer, E. O., P. & S., Balt., '94, Hartford
Ely, J. G., B.S., Wesleyan, '17, Harvard, '23, Lyme
Ematrudo, F. R., Eclectic, Cinn., '21, Hamden
Emmett, F. A., Yale, '02, Hartford
Enander, F. C., Tufts, '22, New Britain
Enders, T. B., B.A., Yale, '88, P. & S., N. Y., '91, Mystic (Hartford Co.)
Engelke, C., P. & S., N.Y., '02, Waterbury
English, C. F., B.S., St. Louis, U., '12, Winsted
Errico, L., B.A., Yale, '18, Yale, '21, New Haven
Esposito, J. J., B.A., Yale, Columbia, '37, New York City (Fairfield Co.)
Evans, T. S., B.A., Yale, '17, B.S., Columbia, '19, P. & S., N.Y., 21, New Haven
Evarts, J., B.A., Vassar, '24, P. & S., N.Y., '29, Cornwall Bridge
Ewell, J. W., Harvard, '36, Farmington
Fabricant, S. E., Jefferson, '19, Waterbury
Fagan, F. X., Ph.B., Brown, '29; Cornell, '33, Hartford
Fancher, H. W., B.S., St. Johns, '21, Univ., Md., '25, Thompsonville
Farland, V. L., B.A., Joliette, '20, Montreal U., '25, Hartford
Fauver, E., P. & S., N.Y., '09, Middletown
Fawcett, G. G., Cornell, '15, South Norwalk
Fay, W. J., B.A., '10, Harvard, '14, Hartford
Fekety, S. H., Tufts, '30, Middletown
Felt, P. R., B.A., Dartmouth, Dartmouth, '10, Middletown
Felty, A. R., B.A., Yale, '16, Johns Hopkins, '20, Hartford
Fenney, P. W., B.S., N.Y.U., '27, Tufts, '31, New Haven
Ferguson, H. K., B.S., Conn. Coll., '25, N.Y.U. & Bellevue, '32, New London
Ferguson, R. C., B.A., Yale, '18, Yale, '20, Rockville
Ferguson, R. J., Hahn, Phila., '89, New Haven
Ferris, H. B., B.A., Yale, '87, Yale, '90, New Haven
Filson, R. M., B.A., Queen's, '13, Queen's, '15, Garden City, L. I., N. Y. (Hartford Co.)
Fincke, C. L., B.A., Harvard, '24, Harvard, '28, Stamford
Findorak, F. G., B.S., Georgetown, '32, Stratford
Fine, B., B.S., Univ. Pa., '28, Jefferson, '32, Stamford
Fine, J., Univ., Pa., '31, Stamford
Finkelstein, W., Harvard, '34, Waterbury
Finkelstone, B. B., P. & S., Balt., '10, Bridgeport
Finley, G. C., Tufts, '24, Hartford
Finn, A. J., B.A., Bowdoin, '17, Bowdoin, '21, Waterbury
Finn, E. J., Yale, '10, Shelton
Fischer, W. J. H., Yale, '11, Milford
Fisher, J. W., Wom. Med., Pa., '93, Middletown
Fiske, M., B.A., Vassar, Boston U., 27, Stamford
Fiskio, P. W., B.S., Yale, '24, Yale, '27, New Haven
Fitzgerald, C. J., Univ. Vt., '98, New Haven
Fitzpatrick, E. E., Ph.G., R. I. Coll. Phar. '07, Univ. Md., '15, Waterbury
Fitzpatrick, W. F., Cornell, '38, Norwalk
FitzSimons, E. F., Tufts, '24, New Haven
Flaherty, C. V., Yale, '10, Hartford
Flaherty, J. E., Georgetown, '08, Rockville
Flanagan, W. F., Fordham, '17, New Britain
Fleck, H. W., Jefferson, '96, Bridgeport
Flynn, C. T., Yale, '11, New Haven
Flynn, D. A., Yale, '05, New Haven
Flynn, H. A., B.A., Yale, '23, Yale, '27, New Haven
Flynn, W. H., Univ. Md., '16, Bristol
Foley, F. X., A.B., Boston U., 34, Bridgeport
Foote, C. J., B.A., Yale, '83; M.A., Yale, '90, Harvard, '87, New Haven
Foote, F. M., D.Ph., Yale, '35, Yale, '33, Hartford
Formichella, J. B., Univ. Naples, '98, Bridgeport
Foster, E. W., B.A., Kansas, '16, Harvard, '24, Meriden
Foster, J. H., B.S., Colby, '03, Univ. Pa., '17, Waterbury
Foster, L. C., B.A., Univ. Kansas, '19, Harvard, '23, New Haven
Foster, W. W., Harvard, '82, Washington, D.C., (Windham Co.)
Fox, J. C., Jr.,B.A., Williams, '16, Johns Hopkins, '20, New Haven
Frank, H. S., B.A., Wesleyan, '21, P. & S., N.Y., '24, Middletown
Freedman, B. P., Ph.B., Yale, '17, Yale '20, New Haven
Freeman, A. C., Univ. Vt., '13, Norwich
Freeman, D., Ph.B., Yale, '20, Yale, '24, New Haven
Freiheit, J. M., B.S., Yale. '24, Yale, '27, Waterbury
Fridberg, S., B.S., Coll. City N.Y., '19, L.I. Coll. Hosp., '28, Stamford
Friedman, I., Geo, Wash., '31, Colchester
Friedman, N. H., B.S., Tufts, Tufts, '33, Stratford
Friend, A. E., Queen's, '22, South Manchester
Friery, C. M., B.A., Harvard, '25, Boston U., '29, Hartford
Frost, L. H., Univ. Vt., '13, Plainville
Frothingham, J. G., A.B., Harvard, Harvard, '35, New Canaan
Fruin, J. W., L. I., Coll. Hosp., '08, Waterbury
Fry, C. C., Northwestern, '24, New Haven
Fulstow, M., Tufts, '20, Fairfield
Furniss, H. W., Howard, '91, Hartford
Gaberman, D., P. & S., N.Y., '20, Hartford
Gade, C. J., Yale, '10, Bridgeport
Gaetz, T. H., McGill, '24, Shelton
Gaffney, C. B., B.S., Pitt., Loyola, '30, Bridgeport
Gaffney, J. J., Loyola, '30, Danbury
Galinsky, D., Trinity, '32, Tufts, '36, Hartford
Gallivan, J. N., B.A., Tufts, '32, Tufts, '35, East Hartford
Gallo, F., B.S., St. Bonaventure, '30, Jefferson, '34, Winsted
Gancher, J., L. I. Coll. Hosp., '06, Waterbury
Gandy, R. A., B.S., Univ. Va., Univ. Va., '27, Stamford
Gandy, R. R., Univ. Pa., '99, Stamford
Ganey, J. M., P. & S., N.Y., '04, New London
Garbelinck, D. A., Boston U., '17, Bridgeport
Garcia, A. G., Univ. Vt., '21, Moosup (New Haven Co.)
Garcin, C. R., C.M., McGill, '25, Danielson
Gardner, C. W., Univ. Md., '01, Bridgeport
Gardener, N. H., Tufts, '34, East Hampton
Garland, R. B., P. & S., Balt., '13, Hartford
Garlick, G. B., Yale, '12, Bridgeport
Garofalo, M. L., Yale, '29, Royal Univ. of Naples, '35, Hartford
Garston, L. E., St. Louis, U., '30, Torrington
Gates, A. B., L.I., Coll. Hosp., '12, Greenwich
Gaylord, C. W., B.A., Yale, '11, Yale '15, Branford
Geck, O. F., Lushing Maximilions Univ., '25, Pomfret Centre
Geer, W. A., Yale, '34, Bridgeport
Geeter, I. S., B.S., Trinity, Jefferson, '29, New Britain
Geib, H. A., Univ. & Bellevue, '14, Milford
Geiger, A. S., B.A., Cornell, '27, Harvard, '30, New Haven
Gendel, B. R., B.S., Tulane, '31, Tulane, '35, New Haven
Genovese, F. T., B.A., N.Y.U., Univ. & Bellevue, '29, Danbury
Genovese, S., Cornell, '11 Danbury
Gentile, A. L., Boston U., '29, New Haven
Geraci, L. A., Ph.B., Yale, '13, P. & S., N.Y., '17, New Haven
German, W. J., Harvard, '26, New Haven
Gettings, J. A., Jefferson, '16, New Haven
Giamarino, H. J., Univ. Me., '06, New Haven
Gianotti, C. C., Albany Med., '18, New Haven
Gibson, C. B., Atlanta Med., '14, Meriden
Gibson, D. F., Ph.B., Yale, Yale, '27, Danbury
Gilday, J. L., Eclectic, Cinn., '13, Bridgeport
Gildea, E. F., A. B., Colorado, '20, Harvard, '24, New Haven
Gildea, M. A. B.S., St. Bonaventure, '22, Buffalo U., '24, Bridgeport

Gildersleeve, C. C., Yale, '96, Norwich
Gildersleeve, G. H., PhB., Brown, '19, Yale, '23, Norwich
Giles, N. W., Univ., Vt., '21, Stamford
Gill, M. H., Yale, '96, Hartford
Gillette, C. W., Jefferson, 95, Westport
Gills, W. L., B.A., Randolph Macon, '05, Johns Hopkins, '12, Hartford
Gilman, R. L., B.A., Harvard, '25, Harvard, '29, Storrs, (Windham Co.)
Gilmore, J. L., Yale, '04, West Haven
Giobbee, M. E., Ph.B., Boston Col., '25, Tufts, '29, Torrington
Giorgio, N. A., B.S., Dartmouth, '22, L.I., Coll. Hosp., '25, Hartford
Gipstein, E., B.A., Harvard, '27, Jefferson, '31, New London
Girouard, J. A., Balt. Med., '99, Willimantic
Gissler, N. E., Yale, '28, Middletown
Giuliano, L. A., Tufts, '32, S. Norwalk
Giuliano, S., B.S., Yale, '26, Tufts, '30, Hartford
Glass, G. C., B.S., Trinity, '27, Yale, '31, Hartford
Glaubman, H. M., B.A., Trinity, '23, Yale, '27, Hartford
Glazer, M., Ph.B., Yale, '18, Tulane, '22, New Haven
Glazier, J. R., Harvard, '22, West Hartford
Goddard, H. B., B.A., Bates, '20, Harvard, '24, East Hartford
Godfrey, E. J., Georgetown, '15, Waterbury
Godfrey, W. T., Cornell, '07, Stamford
Goff, C. W., B.S., Univ. Ill., '22, Univ. Ill., '24, Hartford
Gold, J. D., Ph.B., Yale, '88, P. & S., N.Y., '91, Bridgeport
Gold, L. H., N.Y., Homeo, '32, Hartford
Goldberg, I. S., B.A., Cath. U., '28, Creighton, '33, Torrington
Goldberg, S. J., Yale, '07, New Haven
Goldenberg, J. J., Dalhousie, '26, Hartford
Goldman, G., Yale, '10, New Haven
Goldstein, M., Yale, '24, New Haven
Goldstein, R. M., B.S., Harvard, '21, Johns Hopkins, '30, New Haven
Goldys, W. M., Yale, '09, Waterbury
Goldys, F. M., B.A., Harvard, Tufts, '26, Danbury
Good, W. M., Yale, '09, Waterbury
Goodell, R. A.. Ph.B., Brown, '24, Harvard, '28, Hartford
Goodenough, E. W., B.A., Yale, '87, Yale, '93, Waterbury
Goodman, L. S., M.A., Oregon, '32, Oregon, '32, New Haven
Goodrich, C. A., B.S., Mass. Agr. Coll., '93, P. & S., N.Y., '96, Hartford
Goodrich, W. A., B.A., Yale, '31, Columbia, '35, Waterbury
Gordon, W. F., L.I., Coll. Hosp., '96, Danbury
Gore, M. A., B.A., Geo. Wash., '14, Univ., Md., '18, Bristol
Gorham, G. V., A.B., M.A., U. of Mich., '30, Norwalk
Gosselin, G. A., B.A., Laval, '11, Univ. Vt., '15, Hartford
Gould, M. M., Tufts, '31, Hartford
Gourlie, N. W., Yale, '27, Harvard, '31, Thompsonville
Gourson, N. E., Univ. Vt., '33, Maywood, Calif., (Hartford Co.)
Granniss, I., Yale, '96, Old Saybrook
Grant, A. N., Meharry, '16, Stamford
Grant, A. S., B. S., Wesleyan, Univ. & Bellevue, '08, New Britain
Grau. L. C., Dartmouth, '12, Hartford
Graves, F. G., Yale, '92, Bethlehem (New Haven Co.)
Graves, J. C., Jr., B.A., Amherst, '99, Harvard, '04, Hartford
Gray, A. S., Bellevue, '15, West Hartford
Gray, H. J., B.S., St. Louis, St. Louis U., '21, Newington
Gray, W. H., P. & S., N.Y., '89, Mystic
Green, J. H., Univ. & Bellevue, '13, Waterbury
Greenberg, A., B.S., N.Y.U., L.I. Coll. Hosp., '32, Old Saybrook
Greenhouse, B., Ph.B., Yale, '18, Yale, '21, New Haven
Greenspun, D. S., Ph.B., Yale, 21, Yale, '25, Bridgeport
Grenon, O. A. B.S., Georgetown, '31, Georgetown '33, East Haven
Griffin, D. P., Jefferson, '14, Bridgeport
Grigas, J. E., Tufts, '36, Bethel
Griggs, J. B., Jr., B.A., Yale, '23, Yale, '26, West Hartford
Griswold, A. S., Yale, '21, Bridgeport
Griswold, C., Yale, '24, Bridgeport
Griswold, E. M., Yale, '32, Glastonbury
Griswold, M., B.A., Yale, '25, New Haven, (New London Co.)
Griswold, M. H., Univ. Vt., '13, Hartford
Groark, J. A., B.A., Yale, '21, Yale, '24, New Haven
Groark, O. J., Med. Chi., Phila., '16, Bridgeport
Grodin, H. W., Yale, '17, New Haven
Grosvnor, F. L., Buffalo, U., '00, Hartford
Grout, S. P., Univ., Vt., '04, Newtown
Grower, J. H., B.S., Univ. Neb., '24, Univ. Neb., '25, Middletown
Guida, F. P., B.S., Yale, '31, Yale, '34, New Haven
Gulino, A. J., Tufts, '31, Plainfield
Gura, G. M., B.S., Loyola, '30, Loyola, '31, Southington
Haberlin, C. E., B.Sc., W. Va., Med. Coll. Va., '24, Stratford
Hackett, J. F., B.A., Yale, '03, McGill, '06, Waterbury
Hale, F. B.S., Amherst, '05, P. & S., N.Y., '09, Bridgeport
Hale, V. A., Univ., Texas, '22, Norwich
Haliday, E. G., Queen's, '27, Stonington
Hall, L., B.A., Harvard, '20, Harvard, '24, Hartford
Hall, M. I., Edinburg, '34, Bristol
Hall, W. C., U. of Penna., '30, B.A., U. of Texas, '26, Hartford
Hall, W. E., B.A., Yale, '22, Yale, '25, Meriden
Hamilton, J. S. M., McGill, '26, Stamford
Hanchett, H. B., Jefferson, '05, Torrington
Hankin, M. A., B.S., Yale, '26, L.I., Coll., '33, New Haven
Hankins, M. M., B.A., Salem, '17, Univ. Pa., '25, Mansfield Depot
Hanley, J. P., Cornell, '06, Stafford Springs
Hanrahan, W. R., P. & S., Balt., '05, Bristol
Hansell, H. R., B.A., Univ. Pa., '23, Univ. Pa., '27, Sharon
Hardenburg, D. B., A. B., Yale, Harvard, '34, Bridgeport
Harper, P., A.B., Dartmouth, '26, Yale, '31, Bridgeport
Harrington, A. T., B.A., Yale, '94, Harvard, '10, Hartford
Harrington, J. L., Jefferson, '03, Amherst, Mass., (New London Co.)
Harris, B. R., Ph.B., Yale, '19, Yale, '22, New Haven
Harris, J. S., Yale, '32, New Haven
Harris, L. D., Tufts, '34, Hartford
Harrison, E. R., Yale, '26, New Haven
Harrison, F. M., A.B., Holy Cross, '17, Jefferson, '22, Stamford
Harrison, J. F., Jefferson, '03, Stamford
Harshbarger, I. L., Univ. Va., '22, Bridgeport
Hart, J. C., B.S., Yale, '27, Yale, '30, New Haven
Hart, C. J., Hahne, Phila., '03, New Britain
Hartman, F. B., A.B., Hamilton, '30, Harvard, '34, New London
Harvey, C. C., B.S., Wesleyan, '12, Cornell, '16, Middletown
Harvey, D. F., Yale, '33, Hartford
Harvey, J. LeR., Louisville, U., '14, Waterbury
Harvey, S. C., Ph.,B., Yale, '07, Yale, '11, New Haven
Hastings, L. P., B.Sc., Mass, Agr. Coll., '19, Univ. Vt., '23, Hartford
Hathaway, J. S., Harvard, '28, New Haven
Hatheway, C. M., Univ. & Bellevue, '03, Hartford
Havey, L. A., Univ., Vt., '10, Bridgeport
Haviland, W. C., Balt. Med., '04, Mansfield Depot
Hawthorne, J., Tulane, '20, Greenwich
Haylett, H. B., Univ. Vt., '07, East Hartford
Hazen, D. R., A.B., Amherst, '29, Harvard, '33, Hartford
Hazen, R., B.A., Univ. Vt., '96, Univ. Vt., '98, Thomaston
Heady, C. K., Jefferson, '13, Milford
Heafey, J. R., Syracuse, '34, So. Norwalk
Heidger, L. C., Univ. Vt., '21, Stratford
Hendel, I., Jefferson, '17, New London
Henderson, A. C., B.S., Amherst, '99, P. & S., N.Y., '03, Stamford
Henderson, J. B.S., Smith, '26, P. & S., N.Y., '31, Stamford
Hendricks, A. L., Yale, '07, New Haven
Henkle, E. A., Cornell, '99, New London
Henkle, R. T., B.A., Cornell, '27, Cornell, '31, New London
Hennessey, E. H. J., Univ. Md., '12, Stratford
Hennessey, J. G., Tufts, '34, Bridgeport
Hennessy, J. J., B.A., Dartmouth, '23, P. & S., N.Y., '26, Hartford
Henze, C. W., Yale, '00, New Haven
Hepburn, T. N., B.A., Randolph Macon Coll., Va., '00; M.A., '01, Johns Hopkins, '05, Hartford
Herman, D. W., B.A., Columbia, '21, P. & S., N.Y., '24, Winsted
Herr, E. A., B.A., Dartmouth, '06, Univ., Vt., '09, Waterbury
Herrick, F. L., B.S., Univ., Vt., Univ. Vt., '31, Lakeville
Herrmann, A. E., B.A., Univ. Neb., '18, Harvard, '23, Waterbury
Herrmann, J. B., Ph.B., Yale, '17, Yale '21, New Haven
Hertzberg, G. R., Dartmouth, '99, Stamford
Hertzberg, R. F., B.A., Dartmouth, '23, Harvard, '26, Stamford
Hess, O. W., Buffalo U., '31, New Haven
Hetzel, J. L., Yale, '26, Waterbury
L'Heureux, J. A., B.A., Assumption, '30, Boston, '34, Meriden
Hewes, C. T., Univ., Vt., '31, Groton
Heyer, H. H., U. City N.Y., '87, New London
Heyman, J., Med. Coll. Va., '17, Hartford
Higgins, E. C., Tufts, '25, South Manchester
Higgins, H. E., U. City N.Y., '96, Norwich
Higgins, H. W., B.A., Middlebury, '27, Tufts, '32, Norwich
Higgins, J. J., B.A., Georgetown, '24, Georgetown, '28, New Haven
Higgins, W. L., U. City N.Y., '90, South Coventry
Hill, E. R., Jefferson, '24, Noank
Hill, E. S., McGill, '23, Torrington

Hill, F. J., B.S., Penn. State, Jefferson, '30, Waterbury
Hill, W. E. Bowdoin, '21, Naugatuck
Hillman, M. M. Ph.B., Yale, P. & S., N.Y., '19, New Haven
Hills, L. H., Wom. Med., Pa., '96, Willimantic
Hinchey, R. J., Tufts, '21, Waterbury
Hippolitus, J. D., B.S., Yale, '21, Yale, '25, New Haven
Hippolitus, P. D., Yale, '12, Bridgeport
Hirata, I., Yale, '12, New Haven
Hirschfield, O. M., B.S., Conn. State, '27, Tufts, '31, Hartford
Hirshberg, M. S., Tufts, '27, Hartford
Hitchcock, F. St. C., N.Y., Homeo. '07, Greenwich
Hodgson, T. C., M.B., Toronto U., '94, Trinity Med., '94, Berlin
Hoffman, C. C., Buffalo, U., '16, Hartford
Hogan, W. L., B.A., Holy Cross, '14; M.A., Holy Cross, '24, Univ. Vt., '18, Hartford
Holley, E., Albany Med., '96, Middletown
Hollinshead, J. B., Yale, '37, B.S., Hamilton, '33, Hartford
Holt, K. R., B.S., Dartmouth, '23, Yale, '26, Hartford
Holtz, R. S., Univ. Vt., '28, Hartford
Hopper, E. B., B.A., N.Y.U., '25, Yale, '29, Stamford
Hooper, G. H., Boston U., '29, Bridgeport
Horn, B., B.S., Coll. City N.Y., '25, Univ. & Bellevue, '29, Bridgeport
Horn, M. I., N.Y., Homeo. '15, Bridgeport
Horning, B. G., M.S., Univ., Ore. '22; D.P.H., Johns Hopkins, '32, Harvard, '28, Hartford
Horsefield, T. E., Univ. Vt., '29, Moodus
Hough, P. T., B.S., Trinity, '26, McGill, '32, Hartford
Houle, R. T., B.S., Villanova, '28, Georgetown, '32, East Hartford
Howard, A. J., B.A., Yale, '17, Yale, '20, New Haven
Howard, H. A., Tufts, '29, Wethersfield
Howard, J. H., Georgetown, '18, Bridgeport
Howard, M. E., B.A., Columbia, '26, Johns Hopkins, '31, New Haven
Howe, G. E., B.S., Mass. Agri. Coll., '13, Harvard, '18, Hartford
Howlett, K. S., U. S. Naval Acad., '25, Vanderbilt, '31, Shelton
Hudon, F. A., Penn., '34, '37, Bristol
Hughson, D. T. B.A., Yale, '23, Yale, '27, Madison
Hurlburt, E. G., Vt., '35, Bridgeport
Hunkemier, E., N.Y.U., '33, South Norwalk
Huntington, F. S., B.A., Colgate, '17, Harvard, '24, Darien
Hurwitz, G. H., B.A., Harvard, '29, Univ. Md., '33, Hartford
Hurwitz, H. M., Yale, '12, Hartford
Hutchinson, J. E., B.A., Ohio State U., '09, Johns Hopkins, '14, Hartford
Hutton, G. N., Univ. Toronto, '30, 32' '36, Hartford
Hyde, C. E., Yale, '10, Bridgeport
Hyde, C. J., Univ. & Bellevue, '03, Milford
Hymovich, L., B.S., N.Y.U., '25, Jefferson, '29, U. Toronto, '32 Stamford
Hynes, F. H., Tufts, '13, New Haven
Hynes, T. V., Yale, '00, New Haven
Ignace, S. J., A.B., M.A., Cath. Univ., '26, Georgetown, '30, New Milford
Ingraham, A. E., Tufts, '00, Wethersfield
Ireland, R. M., B.S., Vermont, Vermont, '31, New Milford
Irving, J. G., A.B., U. Toronto, '29, U. Toronto, '32, Hartford
Itzkowitz, H., B.S., Tufts, '30, Tufts, '34, New London
Jack G., Boston U. (Homeo.), '07, New Haven
Jack, J. L., B.S., R.I. State, '15, Yale, '23, New Haven
Jackson, A. F., Howard, '22, B.S., Howard, '18, Hartford
Jackson, A. H. B.A., Princeton, '16, Yale, '24, Washington
Jackson, A. J., P. & S., N.Y., '15, Waterbury
Jackson, E. B., Johns Hopkins, '21, New Haven
Jackson, E. J., Tufts, '19, Waterbury
James A. B., McGill, '27, Bridgeport
James, L. P., B.A., Trinity, '24, Yale, '27, Hartford
Jarvis, H. G., B.A., Yale, '06, Johns Hopkins, '10, Hartford
Jenkins, C. A., Balt. Med., '11, Willimantic
Jenkins, R. H., Med. Coll. Va., '16, New Haven
Jennes, S. W., A.B., Yale '30, Tufts, '34 Waterbury
Johnson, A. A., P. & S., N. Y., '90, Waterbury
Johnson, C. E., B.A., Stan., '22, Harvard, '26, New Haven
Johnson, E. M., Yale, '14, New Haven
Johnson, H. A., Univ. Vt., '25, Naugatuck
Johnston, E. H., Univ. Md., '00, Waterbury
Jones, F. S., Yale, '28, Hartford
Jordan, R. H., Virginia, '33, New Haven
Joyce, W. M., Jefferson, '17, Middletown
Kahn, E., Munich, '11, New Haven
Kalett, J., Jefferson, '28, New Britain
Kalin, J. I., B.A., Clark, '20, Harvard, '24, Hartford
Kalman, E., Komensky, Czechoslovakia, '23, Bridgeport
Kane, J. H., Md. Med., '04, Thomaston
Kaprielian, H. K., Univ. Va., '08, Old Greenwich
Kardys, J. A., Geo. Wash., '30, Hartford
Karotkin, R. H., B.S., N.Y.U., '29, Univ. & Bellevue, '32, Hartford
Kaschmann, J., Munich U., '22, Hartford
Katz, D., Univ. Vt., '22, Univ. Vt., '25, Hartford
Katz, H., B.A., Yale, '17, Harvard, '21, Hartford
Kaufman, C., Jefferson, '19, New London
Keating, J. J., B.S., Niagara, Bellevue, '34, New Milford
Keddy, R. A., McGill, '24, Stamford
Keefe, G. G., B.A., Holy Cross, '18, Univ. Md., '22, Hartford
Keefe, R. S., B.A., Holy Cross, '20, Boston U., '25, Hartford
Keefe, W. J., B.A., Holy Cross, '27, Univ. Md., '31, Hartford
Keegan, D. F., B.A., Catholic Univ., Univ. Md., '21, Bridgeport
Keeney, R. R., Jr., B.S., Trinity, '30, Tufts, '34, Manchester
Keith, A. R., B.A., Colby, '97, Harvard, '03, Hartford
Kellogg, H.K.W., B.S., Amherst, '89, P. & S., N.Y., '03, Norwalk
Kelly, C. C., B.S., Davidson, '09, Johns Hopkins, '14, Hartford
Kelly, J. F. C., Queen's, '2[illegible], Old Greenwich
Kelly, J. F., Hartford
Kendall, R. E., Johns Hopkins, '21, Hartford
Kennard, M. A., Cornell, '30, New Haven
Kennedy, R. C., A.B., B.S., U. of Kansas, '27, Fairfield
Kennedy, W. C., Georgetown, '10, Torrington
Kettle, R. H., Queen's Univ., '28, Norwich
Kezel, A. P. C., B.S., Georgetown, '35, Stamford
Keys, R. C., A.B., B.S., U. of Kansas, '27 Fairfield
Kilbourn, A., B.A., Yale, '21, B.S., Yale, '22, Yale, '23, Hartford
Kilbourn, C. L., Yale, '97, New Haven
Kilbourn, J. B., B.A., Trinity, P. & S., Balt., '11, Hartford
Kilgus, J. F., Univ. Md., '31, Litchfield
Kingman, J. H., B.A., Yale, '82, P. & S., N. Y., '85, New Haven (Middlesex County.)
Kinsbury, I. W., B.A., Harvard, '96, P. & S., N.Y., '03, Hartford
Kinney, K. K., B.S., Iowa Univ. Iowa, '21, Willimantic
Kinsella, M.A., Tufts, '12, New Britain
Kirschbaum, E. H., Yale, '12, Waterbury
Klatskin, G., A.B., Cornell, '29, Cornell, '33, New Haven
Klebanoff, H. E., B.A., Yale, Yale, '25, New Haven
Kleiman, A. O., Tufts, '28, Tufts, 33, Hartford
Klein, A. A., Louisville, U., '29, Hartford
Kleiner, S. B., Ph.B., Yale, '11, Yale, '15, New Haven
Klinghoffer, K. A., B.A., N.Y.U., '27, M.A., Columbia, '28, Yale, '34. New Haven
Klumpp, T. G., B.S., Princeton, '24, Harvard, '28, Washington, D. C. (New Haven Co.)
Knapp, C. S., B.A., Colgate; M.S., Colgate, P. & S., N. Y., '19, Greenwich
Knapp, C. W., P. & S., N. Y., '12, Greenwich
Knapp, R. P., P. & S., N. Y., '11, South Manchester
Knauth, M. S., Columbia, '23, Wilton
Kneale, H. B., B.A., DePauw, Univ., '15, Johns Hopkins, '20, Bridgeport
Koufman, W. B., B.S., William & Mary, '31, Tufts, '35, New Haven
Knowlton, D. J., B.A., Harvard, Harvard, '12, Greenwich
Knowlton, M., C.P.H., Harvard & Tech., '18, Med. Coll. Ind., '05, Hartford
Kornblut, A., Univ. & Bellevue, '20, Bridgeport
Kott, J. H., A. B., Columbia, '30, Bellevue, '33, Torrington
Kowalewski, V. A., B.A., Yale, '99, Yale, '02, West Haven
Krinsky, C. N., Tufts, '33, New London
Krosnick, M. Y., B.A., Yale, '26, Yale, '30, New Haven
Kuh, C., B.A., Cornell, '14, Yale, '32, New Haven
Kunkel, F. E., Yale, '26, Hartford
Kushlan, S. D., Yale, '35, New Haven
La Bella, L. O., B.A., Wesleyan, P. & S., N. Y., '25, Middletown
Labensky. A., Yale, '21, New London
LaBrecque, F. C., A.B., Boston Coll., '31, Tufts, '35, Waterbury
Labuz, E. F., Tufts, '37, B.S., Tufts, '33, Bristol
Lambert, G. S., A.B., Columbia; P. & S., N.Y., '28, Danielson
Lambert, H. B., Jefferson, '09, Bridgeport
Lampson, E. R., B.A., Trinity, '91, P. & S., N. Y., '96, Hartford
Lampson, R. S., A.B., Amherst, '30, Harvard, '34, Hartford
La Moure, C. TenE., Albany Med., '94, Mansfield Depot
Landry, A. B., Jefferson, '09, Hartford

Landry, B. B., B.A., Holy Cross, '16, Harvard, '20, Hartford
Lang, W. P., Hahn, Phila., '01, North Haven
LaPalme, J. A., Tufts, '25, Putnam
LaPierre, A. J., Univ. Vt., '10, Norwich
La Pume, A. A., B.A., Nicolet Sem., '18, Montreal, U., '24, Bristol
LaPointe, J. W.H., Laval, '92, Meriden
Larimore, L. D., Wom. Med. Coll. of Penn., '15, Greenwich
Larkin, C. L., B.A., Yale, '13, Yale, '15, Waterbury
Larrabee, J. W., Harvard, '26, Hartford
Laszlo, A. E., Univ. Kiel, '23, Bridgeport
LaTaif, C. G., Hahnemann, '36, A.B., Syracuse, New Milford
Latimer, M. L., A.B., Wufford, '28, Vanderbilt, '32, New Haven
Lavietes, P. H., B.S., Yale, '27, Yale, '30, New Haven
Lawlor, M. J., Holy Cross, '02, P. & S., N.Y., '06, Waterbury
Lawson, S. J., Univ. Va., '05, New London
Lawton, F. L., Ph.B., Yale, '90, Yale, '93, Hartford
Lawton, R. J., Md. Med., '08, Terryville
Lay, W. S., Yale, '01, Hamden
Leak, R. L., Albany Med., '98, Middletown
Lear, M., Yale, '11, New Haven
Leddy, P. A., Harvard, '24, New Haven
Lee, F. N., B.S., Kansas, '21, Kansas, '23, Milford
Lehman, E. B., Ph.B., Yale, '21, Univ. of Tennessee, '28, New Haven
Leichner, W. Balt. Med., '10, Hartford
Lekston, R. F., Med. Chi., Phila., '15, New Britain
Lena, H. F., B.A., Dartmouth, '12, Johns Hopkins, '16, New London
Lengyel, P., Royal Hungarian Univ. of Budapest, '31, Bridgeport
Leon, A. J., Tufts, '28, Mystic
Leonard, J. C., Yale, '32, New Haven
Leonard, G. A., Md. Med., '05, Waterbury
Leonard, R. J., B.S., Georgetown, '34, Georgetown, '38, Mansfield Depot
Levenson, A., Tufts., '22, Bridgeport
Leverty, C. J., Univ. & Bellevue, '01, Bridgeport
Levin, A. E., Tufts, '30, Hartford
Levin, H. A., B.A., Yale, '15, Univ. & Bellevue, '18, New Haven
Levine, L. W., B.S., Univ. of Maryland '34, Univ. of Maryland,' 37, Ellington
Levine, S. S., P. & S., Balt., '12, Hartford
Levinsky, M., Univ. Md., '28, Bridgeport
Levy, A., B.A., Harvard, '25, Tufts, '31, Winsted
Levy, D. F., Ph.B., Yale, '15, Yale, '19, New Haven
Levy, M. N., Tufts, '23, Bridgeport
Levy, N., B.S., Yale, '23, Yale, '27, Branford
Levy, S. H., Tufts, '35, B.S.U. of Georgia, Stratford
Levy, W., Yale, '11, Suffield
Lewis, D. M., B.A., Yale, '97, Johns Hopkins, '01, New Haven
Lewis, H. R., B.S., Univ. Idaho, '29, Univ. Oregon, '32, Hartford
Lewis, R. M., B.A., Univ. Pa., '06, Univ. Pa., '10, New Haven
Lewis, S. D., Geo. Wash, '31, Brooklyn, N. Y., (Hartford Co.)
Lieberman, D. L., B.S., Union, '22, N.Y.U., '26, Chester
Liebow, A. A., B.S., N.Y.C., '31. Yale, '35, Meriden
Linde, J. I., Yale, '08, New Haven
Lindsay, J. C., B.A., Colby, '16, Harvard, '10, Cheshire
Lindsay, M. K., P. & S., N. Y., '10, Hamden
Lindskog, G. E., B.S., Mass. Agr., '23, Harvard, '28, New Haven
Lirot, S. L. R., McGill, '32, Baltimore (New Haven Co.)
Lischner, M.D., B.S., Trinity, '26, Yale, '30, Hartford
Little, H. C., Yale, '10, New Haven
Little, M. F., B.S., Tufts, '25, Yale, '28, Hartford
Little, M. H., Harvard, '35, Fairfield
Little, O. A. G., Boston Univ. School of Med. '35, Bridgeport
Lobb, R.A., B.A., Wesleyan, '32, Hannemann, '37, Deep River
Locke, H. L. F., Tufts, '12, Hartford
Lockhart, R. H., B.S., Wesleyan, Yale, '28, Bridgeport
Lockwood, H. DeF., Yale, '01, Meriden
Lockwood, J., B.A., Smith, '26, Johns Hopkins, '30, Greenwich
Loffredo, L., B.A., Univ. Pa., '18, Univ. Pa., '22, Middletown
Logan, W. J., Yale, '25, New Haven
Loiacono, A. J., Ph.B., Brown, '23, Harvard, '27, New London
Lombardi, P. F., Tufts, '21, Waterbury
Loomis. F. N., B.A., Yale, '81, Yale, '83, Derby
LoRusso, D. L., B.A., Cornell, '28, Marquette, '34, Torrington
Loveland, E. K., Yale, '97, Watertown
LoVetere, A. A., B.S., Tufts, '31, Tufts, '34, G. Washington, '35 Kensington
Lowe, R. W., U. City N.Y., '89, Ridgefield
Lowsley, O. S., M.A., Stan., '05, Johns Hopkins, '12, New Canaan
Lubchansky, J. H., B.S., '29, Fordham, Bellevue, '33, Uncasville
Lublin, R. D., B.S., Yale, '25, Johns Hopkins, '29, East Hartford
Luby, T. J., McGill, '14, Hartford
Ludlow, G. C., Harvard, '15, Harvard, '19, New Canaan
Lukoski, W. A., F., B.S., Georgetown, '30, Georgetown, '32, Norwich
Lund, F. A., N. Y., Med. & Flower Hosp., Brooklyn (New London Co.)
Lundberg, G.A.F., Jefferson, '19, South Manchester
Lundborg, F. L., M.S., Trinity, '25, Yale, '30, West Hartford
Lyman, D. R., Univ., Va., '99, Wallingford
Lynch, E. J., Univ., Pa., '09, Shelton
Lynch, H., N. Y. U., '34, Westport
Lynch, J. C., U. City N.Y., '86, Bridgeport
Lynch, J. F., Yale, '24, Hartford
Lynch, R. J., Bellevue, '97, Bridgeport
Lynn, J. G., B.S., St. John's, Univ. of Maryland, '29, N.Y.C., (Fairfield Co.)
MacCready, P. B., B.S., Princeton, '16, Johns Hopkins, '21, New Haven
MacCready, W. H., B.A., Acadia, '21, Harvard, '27, Windsor
MacLean, D. R., Balt. Med., '01, Stamford
MacLean, E. M., B.A., Univ. Br. Columbia '24 McGill, '30, West Hartford
Macleod, E. A., Wom. Med., Pa., '25, Niantic
Madden, L. I., B.A., Clark, '05, Harvard, '10, Hartford
Maddren, W. H., B. S., Brooklyn Poly. Inst., ''96 John Hopkins, '01, Freeport, L.I., (Fairfield Co.)
Magnano, J., B.A., Wesleyan, '23, Yale, '27, Middletown
Maher, J. R., B.S., Holy Cross, '21, Boston U., '27, Stratford
Maher, T. F., Yale, '01, Newington
Mahoney, D. F. C., Georgetown, '24, Palm Springs, Cal., (Hartford Co.)
Mahoney, J. J., B.A., Cath. U., '28, McGill, '33, Norwich
Mailhouse, M., Ph.B., Yale, '76, Yale, '78, New Haven
Maine, T. P., Med., Chi., Phila., '12, Mystic
Maislen, S., Univ., Vt., '14, Hartford
Malloy, E. F., B.S., Colgate, '24, Cornell, '28, Stamford
Mancoll, M.M., B.S., Trinity, '24, Jefferson, '28, Hartford
Manwaring, I. J., Univ. Pa., '95, Norwich
Margolius, A. B., Cornell, '29, Cornell, '33, Waterbury
Marglis, B., B.S., Cornell, '15, Bowdoin, '20, Bridgeport
Markoff, K. K., Univ. Vt., '19, Norwich
Marranzini, S., B.S., Trinity, '24, Univ. & Bellevue, '28, Hartford
Marsh, A. D., Yale, '08, Hampton
Marsh, M. L., Eclectic, Cinn., '94, New Britain
Marshall, C. L., B.A., Williams, '20 Howard, '24, New Haven
Martin, J. G., B.S., Yale, '29, Yale, '33, West Hartford
Martin, J. S., Yale, '05, Watertown
Martin, O. L., U. of Kansas, '37, Bristol
Marvin, H. M., B.A., Davidson, (N. C.) '14, Harvard, '18, New Haven
Maslak, R., U. of Louisville, '34, Warehouse Point
Mason, B. H., Med. Sch. Me., '07, Waterbury
Massa, A. F., B.A., Yale, Yale, '18, New Haven
Mastroianni, L., Univ. Padua. '17, New Haven
Mathews, F. P., A.B., Harvard, '30, Southport
Matteis, J. T., Yale, '26, New Britain
Maurer, L. L., B.A., Beloit, '10, Yale, '16, New Haven
Maxwell, J. A., B.A., St. Bonaventure, '10, Med. Coll. Va., '17, Bridgeport
May, G. W., Milwaukee, Med., '95, South Manchester
Maynard, H. H., B.A., Amherst, '11, M.A., Yale, '12, Yale, '16, New Haven
McAlenney, P. F., B.A., Catholic, U., '25, '29, New Haven
McClellan, W. E., Toronto U., '04, Hartford
McCook, J. B., B.S., Trinity, '90, P. & S., N.Y., '94, Hartford
McCormack, C. J., B.S., Yale, '26, M.S., Univ. Minn., '34, Yale, '29 Hartford
McCrann, D. J., Holy Cross, '30, Tufts, '34, Hartford
McCreery, J. A., B.A., '06, M.A., '07, Harvard, P. & S., N.Y., '10 Greenwich
McCue, M. P., B.S., R.I. State, '30, Harvard, '34, East Hartford
McCullough, E. A., A.B., Bowdoin, '90, Harvard, '94, Meriden
McDermott, J. F., B.S., Union, '17, Cornell, '23, Hartford
McDermott, T. S., Yale, '98, Westbrook
McDonnell, R. E., B.A., Yale, 17, Yale, '20, New Haven
McFarland, F. W., B.A., Univ. Vt., '25. Univ. Vt., '28, Stamford
McGaughey, J. D., Jefferson, '10, Wallingford
McGourty, A. F., N.Y. Homeo., '18, Stamford
McGourty, D. P., B.S., N. Y. U., '27, Jefferson, '27, Stamford

McGrath, J. F., B.A., Holy Cross, McGill, '23, Hartford
McGrath, J. H., Yale, '08, Waterbury
McGuire, W. C., Yale, '09, New Haven
McHugh, J. F., Harvard, '01, Thompsonville
McIlroy, P. T., Queen's, '21, New Canaan
McIntosh, E. F., Yale, '97, New Haven
McLarney, T. J., P. & S., Balt., '97, Waterbury
McLaughlin, J. H., P. & S., Balt., '09, Jewett City
McLean, J. C. J., Tufts, '20, Hartford
McLellan, P. G., B.A., Bowdoin, '21, Harvard, '25, Hartford
McLeod, C. E., Univ. Vt., '31, '34, Middletown
McMahon, F. C., Fordham, '19, Stamford
McMahon, G. W., Tufts, '37, A.B., Georgetown, '30, New Britain
McMahon, W. H., Jr., Fordham, '20, South Norwalk
McManus, J. P., P. & S., Balt., '14, Bridgeport
McNulty, T. F., Georgetown, '32, Hartford
McPartland, P. F., Balt. Med., '05, Hartford
McPherson, S. H., Tufts, '13, Hartford
McQueen, A. S., Yale, '01, Branford
McQueeney, A.M., Yale, '05, Bridgeport
Mead, K. C. H., Wom. Med., Pa., '88, Haddam
Meade, C. H. B., Louisville, U., '02, Stamford
Mekrut, J. A., St. Louis U., '31, Meriden
Mendelsohn, W., B.S., Yale, '24, M.S., Yale, '29, Johns Hopkins, '33 New Haven
Mendillo, A. J., Yale, '07, New Haven
Mendillo, J. C. F., B.S., Yale, '26, Yale, '30, New Haven
Menousek, J. A., Univ. Vt., '32, Plainville
Merrill, W. T., B.A., Dartmouth, '87, Dartmouth, '90, East Milton Mass. (New Haven Co.)
Merriman, M. H., B.A., Yale, '01, P. & S., N.Y., '06, Waterbury
Meschter, E. F., Med. Chi., Phila., '98, Stamford
Metcalf, E. H., Jefferson, '14, Rockville
Meyer, F. M., Ph.G., Columbia, '19, B.S., Univ. Ind., '26, Univ. Ind. '28, Bridgeport
Meyers, R. A., B.A., Univ. Mich., Univ. Mich., '31, Watertown
Michalowski, V. S., Boston U., '29, New Britain
Middlebrook, L. F., Jr., B.S., Yale, '26, Johns Hopkins, '30, Hartford
Mignone, J., B.S., Yale, '30, Yale, '33, New Haven
Milano, N. A., B.S., Georgetown, '25, Georgetown, '27, West Haven
Miles, H. S., Ph.G., N.Y., '88, P. & S., N.Y., '91, Bridgeport
Miller, H. B., Univ. Ala., '30, Rush, '33, New Britain
Miller, J., B.A., Cornell, '12, Cornell, '15, Norwalk
Miller, J. R., A.B., Yale, '07, Johns Hopkins, '11, Hartford
Millet, J. A. P., A.B., Harvard, '10, Harvard, '14, New York City (Fairfield Co.)
Mills, B. L., Univ. Vt., '25, Meriden
Minor, L. W., Trinity, '27, Yale, '32, Middletown
Mirabile, C. S., Ph.B., Brown, '25, McGill, '30, Hartford
Mirabile, T. J., Georgetown, '37, East Hartford
Misuk, J. F., B.S., Georgetown, '31, Georgetown, '32, Meriden
Monacella, J. M., P. & S., '35, B. S., Trinity, '31, Windsor
Monahan, O. T., Yale, '33, Bridgeport
Mongillo, F., B.S., Yale, '24, Med. Coll. Va., '28, New Haven
Montano, C. C., Tufts, '32, Tufts, '35, Hartford
Montano, R. A., B.S., Trinity, '29, Tufts, '33, Hartford
Mooney, S., Tufts, '27, Bridgeport
Moorad, P. J., B.S., Hobart, Rochester U., '31, New Britain
Moore, C. D., Queen's, '28, Newtown
Moore, D. DeC. Y., N.Y., Homeo, '95, South Manchester
Moore, H. D., Hahn, Phila., '93, Danbury
Moore, H. F., Mo. Med., '98, Bethel
Moore, H. H., Univ. Vt., '98, Stafford Springs
Moore, M. R., Greens, Univ., '29, Norwich
Moore, W. J., B.A., Columbia, '19, P. & S., N. Y., '21, Cheshire
Moran, J. P., U. of Maryland, '36, B.S., Fordham, '31, New London
Morgan, W. O., Georgetown, '30, Westport
Moriarity, J. L., Harvard, '96, Waterbury
Moriarty, M. E., Yale, '26, South Manchester
Morrill, H. F., B.A., Bowdoin, '21, Harvard, '25, Waterbury
Morriss, W. H., Johns Hopkins, '12, Wallingford
Morrissey, M. J., P. & S., Balt., '97, Hartford
Morrissey, W. T., B.A., Holy Cross Coll., P. & S., Balt., '09, New Britain
Morse, A. H., Johns Hopkins, '06, New Haven
Morse, L. R., B.S., Colby, '20, Queen's, 26, Hartford (New London Co.)
Morse, W. J., B.S., Univ. Vt., '28, Univ. Vt., '31, New London
Moser, O. A., Yale, '02, Rocky Hill
Mouradian, M. G., Wom. Med., Pa., '13, New Britain
Moxness, B. A., Georgetown, '25, A.B., Geo. Wash., '22, Hartford
Moylan, T. P., Buffalo U., '22, Hartford
Moyle, H. B., B.A., MacMasters, '06; M.A., Clark, '11, Toronto U., '10, Hartford
Mucci, L. A., Amherst, '29, Rochester, '34, New Britain, (New Haven Co.)
Muller, R. A., Hahn, Phila., '03, Waterbury
Mullen J. J., Tufts, '29, Waterbury
Mullins, S. F., Univ. & Bellevue, '06, Danbury
Munson, W. R., Balt. Med., '92, Westport
Murcko, W. S., Marquette, '32, Marquette Med., '37, Torrington
Murdock, T. P., Balt. Med., '10, Meriden
Murphy, B. P., Jefferson, '96, Putnam
Murphy, C. A., B.S., L. I. Coll,. '33, Stamford
Murphy, J., Univ. Pa., '95, Middletown
Murphy, J. J., B.S., St. Mary, '31, Georgetown, '35, Danbury
Murphy, O. L., Univ. Vt., '21, Simsbury
Murphy, T. B., B.A., Harvard, '19, Harvard, '23, Wallingford
Murphy, T. D., Columbia, P. & S., '30, A.B., Catholic Univ., '26, West Hartford
Murphy, T. F., B.A., Catholic U., '29, Jefferson, '33, Hartford
Murray, H. J., Jefferson, '16, Stamford
Murray, T. J., Univ. Md., '10, New London
Murray, T. O., Tufts, '32, Danbury
Murray, W. J., Ph.B., Prov. Coll., Jefferson, '32, Bridgeport
Musselman, L. K., B.S., Pa., Coll., '15, Johns Hopkins, '19, New Haven
Nagle, W. T., Med. Chi., Phila., '14, Southington
Nahum, L. H., Ph.B., Yale, Yale, '16, New Haven
Naylor, J. H., Univ. Vt., '95, Hartford
Neff, W. E., Jr., A.B. Columbia, '29, Columbia, '33, Cheshire
Neidlinger, W. J., B.S., Rutgers, '29, Cornell, '33, Hartford
Nelson, W. N., B.S., Wesleyan, '22, Geo. Wash., '26, Cromwell
Nemoitin, B. O., L. I. School of Med., '34, Stamford
Nemoitin, J. P., P. & S., N.Y., '05, Stamford
Nesbit, R. R., B.A., Holy Cross, '25, Albany '29, New Haven
Nespeco, J. U., B.S., Georgetown, '30, Georgetown, '32, Bridgeport
Nespor, R. W., A.B., Dartmouth, '28, Boston U., '33, Westport
Nestos, P. A., Rush, '14, Bristol
Nettleton, I. LaF., L. I. Coll. Hosp., '98, Bridgeport
Neumann, H. A., L. I. Coll. Hosp., '09, Bridgeport
Neumann, V. F., Univ. Mich., '29, Norwich
Neuswanger, C. H., M.S., Yale, '25, Harvard, '23, Waterbury
Newman, J. T., B.A., Yale, '16, Yale, '19, New Haven
Newton, L., N. Y., Homeo, '31, Bridgeport
Nichols, C. W., Univ. Vt., '20, Bridgeport
Nichols, R. W., Ph.B., Yale, '08, Johns Hopkins, '12, New Haven
Nickum, J. S., Tufts, '18, Bridgeport
Nodelman, J., B.S., Yale, '26, Yale, '29, New Haven
Nolan, D. A., Ph.G., Phila., '93, Med. Chi. Phila., '95, Middletown
Nolan, J. F., B.A., Cath. U., McGill, '32, Bridgeport
Northrop, R. A., B.S., Jefferson, '32, Norwalk
Oberg, F. T., B.A., Clark, '12, Harvard, '16, Hartford
O'Brien, F. J., Fordham, '17, Bridgeport
O'Brien, J. F., Yale, '08, Waterford
O'Brien, W. H. J., Ph.B., Yale, '08, Yale, '12, New Haven
O'Connell, J. F., Univ., Vt., '21, Hartford
O'Connell, M. F., B.A., Yale, '19, Yale, '22, Hartford
O'Connell, P. H., Loyola, '29, Norwich
O'Connell, W. M., Ph.B., Yale, Yale, '17, West Haven
O'Connor, D. S., Bowdoin, '19, New Haven
Oelschlegel, H. C., Jefferson, '11, Torrington
Oeseau, H. T., Jefferson, '26, Stratford
O'Flaherty, E. P., Cornell, '01, Hartford
Ogden, A. W., Hahn, Chicago, '13, Norwich
Ogden, R. T., B.A., Bowdoin, '21, Harvard, '24, Hartford
Olmsted, J. G. M., C.M., McGill, McGill, '25, Hartford
O'Loughlin, T. F., U. City N.Y., '96, Rockville
O'Malley, M. A., Univ. Iowa, '33, Hartford
O'Meara, F. P., N. Y. M. C., '36, Glenbrook
Onderdonk, H. J., N.Y.U., '97, East Hartford
O'Neil, M. L., B.S., Conn. State, '25, Yale, '29, Jewett City
O'Neill, C. W., Yale, '20, Yale, '26, Hartford
Orbach, E. J., Friedrich Wilhelm Univ., Berlin, '24, New Britain
Orlawski, A. W., B.S., Harvard, '32, Tufts, '36, Torrington
Osborn, S. H., C.P.H., Harvard, '15, Tufts, '14, Hartford
Osborne, O. T., M.A., Yale, '99, Yale, '84, New Haven
Osgood, C., P. & S., N.Y., '03, Norwich

O'Shaughnessy, E. J., Univ. & Bellevue, '99, New Canaan
Osmond, R. H., Ph.B., Yale, '17, Yale, '23, Hartford
Otis, F. N., Tufts, '18, Meriden
Otis, I. S., Geo. Wash., '17, Meriden
Ottenheimer, E. J., B.S., Univ. Va., '20, Univ. Va., '22, Willimantic
Oughterson, A. W., M.S., Yale, '24, Harvard, '29, New Haven
Outerson, R. A., Jefferson, '02, Hartford
Oxnard, E. W., A.B., Harvard, '32, Harvard, '36, Cheshire
Padula, R. D., Cinn, C. of Med., '29, '30, Norwalk
Padula, V. D., B.S., Univ. Alabama, '29, M.S., Univ. Alabama, '30, Univ. Rome, Italy, '35, Hartford
Paine, R. C., Dartmouth, '00, Thompson
Paladino, J. S., B.A., Colgate, '22, Boston U., '26, Hartford
Palmieri, M. L., B.A., Brown, '28, Yale, '32, M.P.H., Harvard, '37, Middletown
Palmieri, M. W., B.S., Yale, '27, Royal Univ. Naples, '33, New Haven
Panettieri, A. J., Univ. Vt., '37, Bridgeport
Paolillo, C. G., Yale, '35, Ph.B., Yale, '31, New Britain
Papa, J. S., Tufts, '28, Bristol
Parente, L., B.S., Yale, '27, Emory, '31, New Haven
Paris, M., N.Y.U., '30, South Norwalk
Park, P. A., Univ. Ia. (Homeo), '10, Bristol
Parker, J. W., Yale, '06, Hartford
Parlato, H. A., Penn. '31, N.Y.U., '36, New Britain
Parlato, M.A., Yale, '08, Derby
Parmelee, B. M., Univ. Vt. '19, Bridgeport
Parmelee, E. K., L.I., Coll. Hosp., '89, Ansonia
Parrella, L. A., B.S., Yale, '30, Tufts, '34, North Haven
Parshley, P. F., Univ. Pa., '27, West Hartford
Partridge, W. P. B.A., Harvard, '16, Harvard, '20, Hartford
Pascal, T. J., B.S., Yale, '27, Rush, '31, Bridgeport
Patterson, D. C., P. & S., Balt., '06, Bridgeport
Patterson, F. A., B.A., New Brunswick, Harvard, '27, Norwalk
Paul, J. R., B.A., Princeton, '15, Johns Hopkins, '19, New Haven
Paul, V. A., Hahn., Chicago, '13, Stamford
Peacock, A. U., A.B., Colby, '27, Rush, '33, Hartford
Peacock, A. U., A.B., Colby, '27, Rush, '33, Hartford
Peck, R. E., Ph.B., Yale, '90, Yale, '93, New Haven
Pelz, S., Univ. of Austria, '32, Wallingford
Pendleton, C. E., Yale, '03, Colchester
Pendleton, E. R., P. & S., Boston, '04, Granby
Penner, S. L., Columbia, '34, Stratford
Pennington, H. F., B.S., Rutgers, '23, Harvard, '27, Meriden
Pepe, C. T., B.A., Yale, '19, Hahn, Chicago, '22, Derby
Perdue, R. E., Starling, '95, Norwalk
Perakes, G. P., B.S., Georgetown, '31, Georgetown, '32, New Britain
Perham, W. S., B.S., Mich., '28, Mich., '32, New Haven
Perkins, C. W., Hahn, Phila., '01, Norwalk
Perreault, J. N., Tufts, '07, Danielson
Perrins, H. B., B.A., Yale, '16, Yale, '18, New Haven
Perry, M. J., Wom. Med. Homeo, N.Y., '03, Norwalk
Peters, H. LeB., B.A., Univ. B. N., McGill, '07, Bridgeport
Peters, J. P., B.A., Yale, '08, P. & S., N.Y., '13, New Haven
Peterson, C. K., Tufts, '05, Lakeville
Petrelli, J., Ph.B., '21, Yale, '21, Yale, '25, New Haven
Petrucelli, R. J. Columbia, '34, Meriden
Phelps, M. O., B.S., McGill, '25, McGill, '29, Hartford
Phelps, P. S., McGill, '30, Hartford
Phillipson, S., N.Y., Homeo, '18, New Haven
Phillips, A. N., P. & S., N.Y., '83, Glenbrook
Phillips, F. L., Ph.B., Yale, '02, Yale, '06, New Haven
Phillips, H. S., Toronto, U., '22, Westport
Phillips, K. T., Tufts, '19, Putnam
Phillips, P. L., Cornell, '30, A.B., Bowdoin, '24, Hartford
Piasecki, J. L., Maryland, '12, Norwalk
Piasta, P. F. Boston U., '24, Middletown
Piazza, G. J. B.S., Fordham, '28, Boston U., '32. New Haven
Pierson, L. A., Tufts, '27, Meriden
Pierson, E. M., B.A., Vassar, '07; M.A., Columbia, '08, Yale, '24, Cromwell
Pike, E. R., Univ., Mich,. '98, East Woodstock
Pike, M. M., B.A., Brown, '21, Harvard, '25, Hartford
Pileggi, P., Univ. Md., '28, Bridgeport
Pine, C. S., B.A., Univ. Mich., '33, Univ. Mich., '31, Naugatuck
Pinn, A. S., Laval, '29, New Haven
Pinney, A. W., Hahn., Phila., '00, Norfolk
Pinney, R. W., P. & S., N.Y., '88, Derby
Pitock, M. P., B.A., '25; M.A., '26, Franklin & Marshall, Tufts, '30, Fairfield
Platt, I. S., Univ. S. Calif., '12, Waterbury
Platt, W. L., P. & S., N.Y., '81, Norwich (Litchfield Co.)
Plukas, J. M., Georgetown, '32, Bridgeport
Plunkett, T. F., L. I. Coll. Hosp., '08, Derby
Pola, W. E., Loyola, '37, B.S., U. of Louisville, '32, New Britain
Polito, F. L., Ph.B., Yale, '17, Yale, 21. Torrington
Pomeroy, N. A., P. & S., N.Y., '96, Waterbury
Poole, A. K., B.S., Princeton, Johns Hopkins, '23, New Haven
Post, E. A., A. B. Mt. St. Mary's, '29. Georgetown, '33, Waterbury
Potter, F. E., B.A., Williams, '85, P. & S., N.Y., '89, Middletown
Poverman, D., B.S., Vermont, '29, Vermont U., '32, New Haven
Powell, W., B.A., Queen's, '21, Queen's, '24, New Haven
Powers, G. F., B.S., Purdue, '08, Johns Hopkins, '13, New Haven
Pratt, A. M., Bellevue, '92, Deep River
Pratt, A. P., B.A., Clark, '13, C.P.H., Mass. Inst. Tech., '16, Harvard, '22, Windsor
Pratt, E., P. & S., N.Y., '87, Torrington
Pratt, N. T., B.A., Trinity, '94; M.A., Trinity, '97, Yale, '04, Old Saybrook (Fairfield Co.)
Preston, T. R., B.A., Yale, '21, Yale, '25, Hartford
Priddy, F. E., B.S., Northwestern, '27, Northwestern, '28, Hartford
Prout, E. B., Univ. Syracuse, '14, Portland
Pullen, R. W., B.S., Univ. Wisc., '19, Yale, '21, New Britain
Purinton, C. O., Ph.B., Yale, '97, Yale, '00, Summount, N.Y., (Hartford Co.)
Purney, J., Balt. Med., '06, New Britain
Pyle, E., P. & S., N.Y., '15, Waterbury
Quatrano, J. C., Univ. Vt., '31, Bridgeport
Quarrier, S. S., B.S., Yale, '28, P. & S., N.Y., '32, Hartford
Quinlan, R. V., M.Sc., (Med.) Univ. Pa., '27, Balt. Med., '10, Meriden
Quinn, J. F., Balt. Med., '06, Bridgeport
Quinn, R. J., P. & S., Balt., '13, Waterbury
Quintiliani, A., B.A., Harvard, '25, Harvard, '29, Norwich
Rabinovitch, A., Univ. Vt., '19, New London
Rademacher, E. S., Univ. Iowa, '23, New Haven
Radin, M. J., B.A., Yale, '14, P. & S., N.Y., '16, Hartford
Radom, M. M., Jefferson, '25, Hartford
Raffa, J. Columbia, '34, B.S., Trinity, '30, Glastonbury
Rafferty, B., Jefferson, '28, Willimantic
Rand, R. F., Ph.B., Yale, '95, Johns Hopkins, '00, New Haven
Randall, W. S., Ph.B,. Yale, '83, P. & S., N.Y., '86, Shelton
Rankin, B. F., Ph.B., Yale, '13, McGill, '19, Hartford
Rapp, A. G., B.S., Harvard, '26, Cornell, '29, New London
Rasmussen, H. N., Tufts, '25, Uncasville
Rawls, E. C., B.S., Va., '31, Stamford
Raymer, J. G., B.A., Harvard, '25, Norwich
Raynolds, R., B.A., Yale, '09, P. & S., N.Y., '14, Hadlyme
Read, F. A., A.B., Clark, U., Yale, '34, Old Greenwich
Reade, E. G., Jefferson, '16, Watertown
Reardon, W. F., Balt. Med., '04, Hartford
Reich, U. S., Univ. Va., '09, Bridgeport
Reichenbach, F., Tufts, '33, Waterbury
Reidy, D. D., B.A., Harvard, '23, P. & S., N.Y., '27, Hartford
Reidy, M. J., P. & S., N.Y., '10, Winsted
Reilly, F. H., Yale, '97, New Haven
Reilly, W. J. Tufts, '35, Naugatuck
Renehan, J. M., Tufts, '28, Ansonia
Rentsch, S. B., Univ. Mich., '23, Derby
Resnik, E., B.A., Yale, '25, McGill, '30, New Britain
Resnik, W. H., Ph.B., Yale, Johns Hopkins, '21, Stamford
Resnisky, A. F., Georgetown, '23, Hartford
Reynolds, H. St. C., Yale., '10, Hartford
Reynolds, H. S., B.S., Union Coll., '11, Albany Med., '14, Hartford
Reynolds, J. A., A.B., Holy Cross, '32, Tufts, '36, Waterbury
Reynolds, R. G., B.S., Trinity, '22, Harvard, '26, Hartford
Reynolds, W. M., A.B., Cornell, Columbia, '31, Greenwich
Ribner, H., B.S., Tufts, '34, Bridgeport
Riccitelli, M. L., Ph.B., Yale, '19, Yale, '22, New Haven
Richardson, R. A., Univ. Vt., '14, Bristol
Ricksher, C., B.S., Parsons, '01, Johns Hopkins, 05, Norwich
Rilance, A. B., Univ. Britain Coll., '28, McGill, '31, Shelton
Rindge, M. P., P. & S., Cleveland, '05, Madison
Rindge, N. P., B.S., '32, Yale, '35, Clinton (Middlesex Co.)
Riordan, M. D., Univ. Vt., '12, Willimantic
Riordan, W. J., Univ. Md., '09, Wallingford
Robbins, B. B., U. City N.Y., '94, Bristol
Robbins, C. L., Yale, '29, New Haven
Roberts, D. J., Univ. Vt., '16, Hartford

Roberts, E. R., Med. Sch. Me., '13, Bridgeport
Roberts, F. W., Johns Hopkins, '24, New Haven
Robinson, A. J., Toronto U., '23, Hartford
Robinson, W. J. T., L.I., Coll. Hosp., '21, Broad Brook
Roccapriore, B. A., Niagara, Jefferson, '31, Middletown
Roch, G. E., B.A., Holy Cross, '30, Tufts, '34, Willimantic
Roche, A. F., B.S., Georgetown, '15, Georgetown, '17, Hartford
Roche, T. J., P. & S., Balt., '11, Bridgeport
Rockwell, A. E., Johns Hopkins, '21, Bridgeport
Rogers, F. P., Syracuse Univ., '33, West Hartford
Rogers, O. F., Jr., B.A., Harvard, '08, Harvard, '12, New Haven
Rogers, P. H., Yale, '12, West Haven
Rogers, R. P., B.A., Harvard, '21, Harvard, '25, Greenwich
Rogol, L., B.S., Yale, '29, L.I. Coll., '33, Danbury
Rogol, O., Ph.B., Brown, '20, Dalhousie, '32, Seymour
Rogowski, B. A., Ph.B., Yale, '20, New Haven
Rollins, H. B., B.S., Dartmouth, '20, Yale, '22, Hartford
Romaniello, R. J., B.A., Holy Cross, '23, P. & S., N.Y., '27, Hartford
Rooney, J. F., Balt. Med., '03, Hartford
Root, J. H., Ph.B., Harvard, '18, Waterbury
Root, M. T., B.A., Cornell, '15, Cornell, '18, West Hartford
Root, S. Q., Wom. Med. Homeo.,N.Y., '96, Stamford
Root, S. A., B.A., Barnard, '14; M.A., Columbia, '15, Cornell, '19, West Hartford
Rose, S. A., N.Y.U. & Bell., '23, Stamford
Rosenbaum, G. J., B.S., Trinity, '30, Tufts, '34, Hartford
Rosenthal, E., Univ. of Wurtenberg & Munich, '24, Hartford
Rosenthal, I., L.I. Coll., '10, South Norwalk
Ross, A. M., Univ. of Basel '35, Darien
Roth, F. E., Univ. & Bellevue, '25, Hartford
Rothblatt, R., Tufts, '32, A.B., Harvard, '37, Willimantic
Rothschild, M. L., Ph.B., Yale, '19, Paris U., '26, New Haven
Rowell, E. E., Hahneman, '99, Stamford
Rowley, A. M., Univ. Vt., '97, Hartford
Rowley, J. C., B.A., Harvard, '02, Harvard, '06, Hartford
Rowley, R. L., Yale, '03, Hartford
Roy, J. L., B.A., Clark, '30, Tufts, '34, North Grosvernordale
Rubin, G. A., Edinburgh, '32, New Haven
Ruby, M. H., Ph.B., Yale, '18, P. & S., N.Y., '21, Waterbury
Ruby, R. J., Baylor, '36, Waterbury
Russell, E. F., B.A., Yale, '16, Cornell, '20, Santa Barbara, Cal. (New Haven Co.)
Russell, G. G., B.A., Harvard, Harvard, '19, Hartford
Russell, J. J., N.Y., Homeo, '87, Putnam
Russell, T. H., Ph.B., Yale, '06, Yale, '10, New Haven
Russell, W. I., Yale, '09, New Haven
Russman, C., Tufts, '23, Middletown
Russo, J. D., Ph.B., Yale, '12, Yale, '16, New Haven
Ryan, F. J., B.S., Trinity, '30, Tufts, '35, Hartford
Ryan, T. M., B.A., Loyola Coll. Balt. Med., '02, Torrington
Ryder, R. H., P. & S., Balt., '13, Waterbury
Ryder, W. H., Jefferson, '20, New Haven
Rynard, W. M. W., Toronto U., '24, Stamford
Sabloff, J., L. I. Coll. of Med., '34, New London
Salinger, R., Johns Hopkins, '25, New Haven
Salmond, P. H., Univ. Manitoba. '20, North Battleford (Fairfield Co.)
Salvin, B. L., Geo. Wash., '21, Hartford
Samponaro, N., B.S., Trinity, '25, Johns Hopkins, '29, Hartford
Sanderson, R. V., Univ. Vt., '20, Winsted
Sanduli, G. R., B.A., Harvard, '25, Tufts, '29, Waterbury
Sanford, C. E., Yale, '06, New Haven
Santoro, G. M., B.A., Cornell, '24, Waterbury
Satti, C. J., Yale, '23, New London
Savarese, M. F. R., L. I. College of Med., '11, New Haven
Sayers, D. O. C., B.S., Conn. State, '31, Tufts, '35, Waterbury
Sayers, J. J., B.S., Trinity, '30, Tufts, '35, Hartford
Scafarello, P. J., Tufts, '26, Hartford
Scanlon, J. J., B.S., Georgetown, Georgetown, '35, South Norwalk
Scanlon, T. F., Yale, '07, Norwalk
Scarborough, M. McR., B.A., Univ. Oregon, '02; M.A., Yale, '05, Yale, '07, New Haven
Schaefer, A. M., Ph.B., Yale, '21, Yale, '25, Hartford
Schaefer, J., Tufts, '17, Hartford
Schechtman, C. T., Univ. Vt., '26, New Britain
Schiavetti, A., B.A., Columbia, '26, Tufts, '30, Stafford Springs
Schmidt, N. L., B.S., Yale, Vanderbilt, '27, Stamford
Schneider, W., B.S., N.Y.U., '27, B.S., (Med.) Univ., Kan., '28, Geo. Wash., '30 Rockville
Scholl, R. F., Yale, '12, New Haven
Schuman, D. H., B.S., Columbia, '20, P. & S., N.Y., '22, Hartford
Schupack, S. D., Tufts, '24, New Britain
Schwartz, P. E., Tufts, '31, Portland
Scott, C. R., B.S., Westminister, '15, Yale, '19, New Haven
Scott, J. C., B.S., Haverford, '29, U. of Penn., '33, Essex
Scott, W. J., Fordham, '16, Derby
Scoville, D. H., Cinn. U., '30, New London
Scudder, W. D., Harvard, '20, Hartford
Scully, R. T., Fordham, '30, Georgetown, '35, New Britain
Seabury, R. B., Harvard, '18, New Haven
Sears, L., Harvard, '29, Norwich
Segel, S., B.S., Vermont, '31, Vermont, '35, Norwich
Segnalla, E., Yale, '12, New Haven
Segur, G. C., P. & S., N.Y., '82, Hartford
Seibert, A. F., Yale, '27, Hartford
Sekerak, A. J., Univ. Md., '22, Bridgeport
Sekerak, R. A., Maryland, '29, Bridgeport
Sekerak, R. J., Maryland, '34, Bridgeport
Selinger, J., Georgetown, '13, New Canaan
Selleck, N. B., L.I. Coll. Hosp., '24, Danbury
Sellew, R. C., Yale, '98, Canaan
Sellew, R. C., Jr., B.S., Yale, '32, L.S. Med. Coll., '36, North Canaan
Senfield, M., Univ. Vienna, '20, Ansonia
Serafin, P. J., B.S., Dartmouth, '18, N.Y.U., '21, MSc, Penn. '36, New Haven
Serrell, H. P. B.S., Dartmouth, '28, Cornell, '32, Greenwich
Sette, A. J., Geo. Wash., '27, Stamford
Shafer, A., Univ. Pa., '18, Hartford
Shaffer, T. E., Cornell, '29, Cornell, '32, New Haven
Shain, J. H., Tufts, '28, South Norwalk
Sharp, L. I., McGill, '35, B.S., McGill, '31, New York City (Hartford Co.)
Shaw, G. H., Syracuse, U., '08, Hartford
Shaw, L. E., Wom. Med. Coll. of Penn., '22, Greenwich
Shay, F. L., Ph.B., Yale, '21, Tufts, '25, New Haven
Shea, C. J. Maryland, '33, Bridgeport
Shea, D. E., Loyola, '17, Hartford
Shea, J. F., P. & S., Balt., '11, Bridgeport
Shea, M. S., Univ. Vt., '21, New Haven
Shea, R. E., Yale, '30, Willimantic
Shea, R. O., P. & S., Balt., '14, Bridgeport
Shea, V. T., Tufts, '31, Waterbury
Sheahan, W. L., P. & S., Balt., '12, New Haven
Sheehan, M. T., Yale, '10, Wallingford
Shepard, W. G., Toronto U., '08, Hazardville
Shepard, W. M., B.A., Dartmouth, '25, P. & S., N.Y., '29, Putnam
Sherer, H. C., U. City N.Y., '92, South Norwalk
Shermak, J. V., Univ. Vienna, '19, Old Greenwich
Sherman, S. N., A.B., Dartmouth, '31, Columbia, '34, Stamford
Sherwood, H., Univ. of New Hampshire, '32, N.Y. Med., '37, Durham
Shirk, S. M., Hahn., Phila., '97, Stamford
Shockley, F. M., Univ. Med. Coll. Kansas C., '13, Stamford
Shulman, D. N. B.A., Johns Hopkins, '13, Johns Hopkins, '17, Hartford
Shure, A. L., Tufts, '27, New Haven
Sigal, J. B., B.S., Trinity, '19, Yale, '23, Hartford
Sigel, H., Tufts, '34, West Haven
Sikes, R. F., B.A., Yale, '31, Yale, '35, Guilford (Middlesex Co.)
Siliciano, R. A., V., Hahn, Chicago, '24, Bristol
Sills, T. H., B.S., Yale, '24, Yale, '27, Newington
Silverberg, S. J., P. & S., N.Y., '21, New Haven
Simmons, E. M. B.A., Bowdoin, '19, Yale, '23, Southington
Simon, L. G., B.S., N.Y.U., '24, N.Y.U., '27, South Norwalk
Simonton, F.F., Med. Sch. Me., '03, Thompsonville
Simses, J. P., Tufts, '37, Bridgeport
Skiff, S. E., Hahn., Phila., '03, New Haven
Skinner, C. E., LL.D., Rutherford, '01, Yale, '91, Darien (New Haven Co.)
Slater, M., Ph.B., Yale, '19, Yale, '24, Hamden
Slavin, J. E., Vermont, '12, Waterbury
Slossberg, D. S., B.S., Trinity, '30, Tufts, '34, Hartford
Slysz, L. B., Boston U., '27, New Britain
Smilgin, V. E., G. Wash. Univ., '38, New London
Smith, A. C., P. & S., Balt., '10, Danbury
Smith, C. S., B.A., Yale, '12, Hahn., Phila., '16, New Haven
Smith, E. D., B.A., Yale, '96, Yale, '99, Bridgeport
Smith, D. P., B.A., Yale, '10, Yale, '12, Meriden
Smith, E. L., Yale, '96, Waterbury

Smith, E. T., M.A., Trinity, '03, Hon., Yale, '97, West Hartford
Smith, F. DeW., Hahn., Phila., '10, Guilford
Smith, F. M., Univ. Vt., '11, Willimantic
Smith, G. A., B.A., Yale, '03, Johns Hopkins, '07, Long Hill
Smith, G. M., B.A., Yale, '01, P. & S., N.Y., '05, Pine Orchard, Branford
Smith, G. M., Univ. Ill., '07, Hartford
Smith, G. T., Yale, '08, Waterbury
Smith, G. Y., L.I. Coll. of Med., '33, Brooklyn, N.Y., (Fairfield Co.)
Smith, J. J., B.A., Columbia, '26, Univ. Md., '30, Bridgeport
Smith, M. U., City N.Y., '83, New Haven
Smith, N. N., Ph.B., Yale, '21, Yale, '24, New Haven
Smith, S. M., Tufts, '20, Greens Farms
Smith, S. R., B.A., Bucknell, '09, Med. Chi., Phila., '16, Bridgeport
Smith, V. J., Univ. Pa, '20, New Britain
Smith, W. B., Univ. Pa, '22, Wethersfield
Smith, W. E., Univ. Mich., '10, Stamford
Smith, W. F., Cornell, '34, Ph.B., Yale, '30, Hartford
Smykowski, B. L., Balt., Med., '11, Bridgeport
Snavely, M. E., B.A., Mt. Holyoke, Yale, '25, West Haven
Sneidman, G. I., Conn. State, '32, Virginia, '36, Hartford
Snelling, P. W., B.A., Univ. Ga., '17, Harvard, '21, Hartford
Snurkowski, C. V., B.A., Georgetown, '25, New Haven
Sollosy, A., Tufts, '27, Bridgeport
Solomon, C. I., B.S., C. City N.Y., '21, Yale, '25, Meriden
Soltz, T., Jefferson, '11, New London
Soreff, L., B.S., Tufts, '28, Tufts, '32, East Hampton
Souther, S. P., B.A., Univ. Neh., '18, Johns Hopkins, '23, Hartford
Spector, N., B.S., Tufts, Tufts, '24, Lynn, Mass. (Windham Co.)
Speight, H. E., Georgetown, '27, Middletown
Spekter, L., Trinity, '29, Univ. Roch., '33, Hartford
Sperandeo, A., Ph.B., Yale, '21, Yale, '25, New Haven
Sperry, F. N., Yale, '94, New Haven
Spicer, E., Yale, '05, Waterhury
Spillane, B. B.A., Dartmouth, '13, Tufts, '16, Hartford
Spinner, S., B.A., Tufts, '32, Tufts, '35, New Haven
Sprague, C. H., P. & S., N.Y., '04, Bridgeport
Squillacote, V. J., B.S., Trinity, '30, Univ. Rome (Italy), '34, New Britain
Stahl, W. M., Univ. Md., '14, Danbury
Standish, E. M., B.S., Wesleyan, '18, Harvard, '22, Hartford
Standish, F. B., Yale, '03, New Haven
Standish, H. C. Cornell, '28, West Hartford
Standish, J. H., U. City N.Y., '95, Hartford
Standish, W. A., B.A., Yale, '22, Yale, '25, Hartford
Staneslow, J. S., B.A., Cornell, '22, Cornell, '26, Waterbury
Starr, R. M., B.S., Mich. State, '17, Yale, '26, New London
Starr, R. S., B.A., Trinity, '97; M.A., Trinity, '00, P. & S., N.Y., '01, Hartford
Starrett, J. E., B.S., Univ. N.H., '26, Tufts, '30, Stamford
Staub, J. H., L.I. Coll. Hosp,, '99, Stamford
Stein, A., Univ., Md., '17, Thompsonville
Steincrohn, P. J., Univ. Md., '23, Hartford
Steiner, W. R. B.A., Yale, '92; M.A., Yale, '95; L.H.D., Trinity, '31, Johns Hopkins, '98, Hartford
Stempa, H., Berlin U., '98, Hartford
Stephenson, C. W., Harvard, '22, Hartford
Stetson, H. W., Univ. Vt., '06, Milford
Stetthacher, H. J., B.S., Bates, '17, Harvard, '22, Waterhury
Steudel, H., Univ. Kiel, '89, Ansonia
Stevens, H. G., Maryland, '04, New Milford
Stevens, M. A., Yale, '29, New Haven
Stevenson, W. R., Boston U., '31, Bristol
Stewart, H. E., Yale, '10, New Haven
Stewart, L. Q., B.S., Middlebury, '26, Yale, '33, West Hartford
Stietzel, E. E., B.S., Yale, '30, Columbia, '34, South Norwalk
St. John, L. A., Fordham, '20, Hartford
Stockwell, W. M., Univ. Pa., '04, North Granby
Stolzheise, R. M., A.B., Willemette, '26, Univ. Oregon, '34, Hartford
Stone, E. L., B.A., Williams, '16, Johns Hopkins, '20, New Haven
Stone, H. R., Wesleyan, '99, Johns Hopkins, '04, Clinton
Stone, M. J., B.S., Chicago, Rush, '22, Stamford
Stone, W. S., P. & S., N.Y., '91, Norwalk
Storms, W. F., Ph.B., Brown, '26, Harvard, '30, Wethersfield
Storrs, E. R , Jefferson, '00, Hartford
Storrs, R. W., B.S., Trinity, '17, Harvard, '20, Hartford
Stoughton, D. H., McGill, '18, Hartford
Strauss, M. J., B.A., Yale, '14, P. & S., N.Y., '17, New Haven
Strayer, E. M., A.B., B.D., Baylor, '24, Columbia, '33, Stratford
Strayer, L. M., Jr., B.A., Princeton, '26, Harvard, '30, Stratford
Stretch, J. E., Geo. Wash., '28, Simsbury
Strickland, H., McGill, '30, Meriden
Stringfield, O. L., B.S., Wake Forest Coll., N.C., Univ. & Bellevue, '16, Stamford
Strobel, J. E., Temple, '09, Greenwich
Stygar, J. S., B.S., St. Louis, '32, St. Louis, '33, Derby
Sullivan, A. J., B.S., Catholic U., '22, Harvard, '27, Washington, D.C., (New Haven Co.)
Sullivan, C. N., Mass., '26, McGill, '30, New Britain
Sullivan, D., N.Y.U., '97, New London
Sullivan, J. F., B.A., Yale, '90, P. & S., N.Y., '94, New Haven
Sullivan, T. J., B.A., Yale, '15, Yale, '17, New Haven
Sulman, M., P. & S., N.Y., '36, New London
Sunderland, P. U., N.Y., Homeo, '94, Danhury
Sunderland, W. A., M.E., Lehigh, Yale, '26, Danbury
Sundquist, A. B., Tufts, '29, Tufts, '33, Manchester
Suplicki, J. W., Tufts, '26, Norwich
Sussler, D., Fordham, '16, Norwich
Sutherland, F. A., B.A., W. & L., '22, Harvard, '26, Torrington
Swan, H. C., Tufts, '03, Hartford
Sweet, A. N., Univ. Md., '18, Middletown
Sweet, G. C., P. & S., Balt., '12, Noroton Heights (New Haven Co.)
Sweet, J. H. T., Jr., Tufts, '12, Hartford
Swenson, A. C., Yale, '02, Waterbury
Swett, P. P., Univ. & Bellevue, '04, Hartford
Tait, A. A., Carthage, '24, Univ. Ill., '27, Univ. Penn., '36, Univ. Ill., '30, West Hartford
Talbot, H. P., Univ. Md., '27, Hartford
Tanner, M. J., Tufts, '18, New Haven
Tanner, W. A., Univ. Vt., '12, Danielson
Tarasovic, T. J., Tufts, '36, Bridgeport
Tate, W. J., B.A., Trinity, '25, Yale, '29, Deep River
Taylor, A., Rush, '29, Hartford
Taylor, C. C., B.A., Dartmouth, Harvard, '16, Bridgeport
Taylor, J. C., Univ. Mich., '91, New London
Taylor, M. W., Tufts, '05, Hartford
Taylor, R. M., B.A., Geo. Wash., '19, Geo. Wash., '22, East Haven
Taylor, R. N., B.S., Yale, '26, Yale, '30, New London
Taylor, S. P., Geo. Wash., '16, North Haven
Teele, J. E., B.A., Tabor, '85, Wom. Med., Pa., '88, Greens Farms, (New Haven Co.)
Tennant, R., B.S., Yale, '26, Yale, '29, New Haven
Terhune, W. B., Tulane, '15, New Canaan
TerKuile, R. C., U. of Roch., '32, Bridgeport
Teuscher, W. P., A.B., Univ. Miami, Tufts, '32 Westport
Thalberg, R. E., B.S., Yale, '23, Yale, '26, Southington
Thayer, R. B., B.S., Bowdoin, '17, Bowdoin, '20, Somers
Thenebe, C. L., Univ. Pa., '18, Hartford
Thomas, J. J., Fordham, '21, Ansonia
Thompson, C. G., N.Y., Homeo, '18, Norwich
Thompson, H. G., B.A., Yale, '13, Harvard, '17, Hartford
Thompson, K. W., A.B., Leland Stanford, Jr., '26 Harvard, '29, New Haven
Thompson, L. E., Boston U., '25, Waterford
Thompson, L. J., Univ. Mo., '19, Wash. U., '19, New Haven
Thompson, S. A., B.A., Wes., '18, Cornell, '23, Greenwich
Thoms, H., Yale, '10, New Haven
Thomson, T. L., B.A., Princeton, '98, Hahn., Phila., '01, Torrington
Throckmorton, V. J., S.B., Boston U., '30, Boston U., '33, Stamford
Tileston, W., Harvard, '95, Harvard, '99, New Haven
Tinkess, D. E., McGill, '25, Greenwich
Tirella, F. F., Tufts, '37, Bristol
Tisher, P. W., Iowa Coll. of Med., '35, New Britain
Todd, F. P., Boston U. (Homeo.), '89, Danielson
Tokarczyk, J. J., Univ. Vt., '20, New Britain
Tolk, N. R., Univ. & Bellevue, '20, Bridgeport
Tomaino, F. F., B.S., Yale, '25, Yale, '29, Danbury
Tombari, S. P., Boston U., '34, Norwich
Tonken, L. C., Trinity, '30, Tufts, '34, Hartford
Toole, F. E., B.A., Yale, '16, Yale, '19, New Haven
Tortolani, A. P., A.B., Brown, '29, C. M., McGill, '34, Plainville
Tovell, R. M., B.A., Queen's, '24, Queen's, '26, Hartford
Tower, A. A., B.A., P. & S., N.Y., '19, Meriden
Towne, N. A., Univ. Vt., '31, Naugatuck
Townsend, W. C., B. S., Amherst, '20, Harvard, '25, Hartford
Tracey, E. J., Ph.B., Yale, '20, Univ. Pa., '24, Norwalk

Tracey, W. J., U. City N.Y., '89, Norwalk
Tracey, W. W., Ph.B., Yale, '12, M.A., Columhia, '16, P. & S., N. Y., '16, Norwalk
Tracy, F. E., B.S., Yale, '26, Yale, '29, Middletown
Tracy, R. G., Yale, '00, New Haven
Trask, J. D., Ph.B., Yale, '13, Cornell, '17, New Haven
Treat, W. H., Yale, '06, Derhy
Trimpert, A. J., B.S., Georgetown, '33, Bethel
Troy, W. D., Jefferson, '36, Stamford
Truex, E. H., Louisville U., '08, Hartford
Tuch, M., Univ. & Bellevue, '06, Hartford
Tukey, F. M., B.A., Bowdoin, '91, Harvard, '94, Bridgeport
Tunick, G. L., Jefferson, '35, A.B., Cornell, Greenwich
Turbert, E. J., Balt., Med., '04, Hartford
Turchik, F., Jefferson, '27, Bridgeport
Turkington, C. H., Ph.B., Yale, '03, Johns Hopkins, '07, Litchfield
Turner, A. R., B.A., Amherst, '84, Univ. Paris, '94, Norwalk
Turnley, W. H., B.S., Florida, Univ. Va., '24, Stamford
Turton, E. H., Boston U., '00, Stamford
Twaddle, P. H., Trinity, '31, Yale, '35, Philadelphia (Hartford Co.)
Tyler, M. B.A., Mt. Holyoke, '13, Johns Hopkins, '17, New Haven
Unsworth, A. C., B.S., Univ. Vt., '28, Univ. Vt., '31, Columbia, Dr. M.Sc., '36, Hartford
Upson, W. H., Tufts, '27, Suffield
Uricchio, J. G., B.A., Catholic U., '26, Georgetown, '31, Hartford
Urquhart, R. G., M.D.C.M., McGill, '24, Norwich
Ursone, F. D., B.S., Tufts, '26, Tufts, '29, Norfolk
Uvitsky, I. H., Boston U., '27, Bridgeport
Vail, G. F., B.S., Villanova, '98, Univ. Pa., '02, Hartford
Vail, T. E., Ph.B., Yale, '07, Johns Hopkins, '11, Thompsonville
Van Antwerp, L. D., B.A., Univ. Mich., '23, Univ. Mich, '31, Meriden
VanCor, C. A., Univ. Vt., '14, Middletown
VanKleeck, E., B.A., Columhia, '10, P. & S., N.Y., '12, Hartford
VanStrander, W. H., Univ. Vt., '00, Hartford
Van Tassel, W., N.Y.U., '27, Darien
Van Wart, W. H., B.A., Bowdoin, '18, Harvard, '22, Hartford
Vastola, A. P. Fordham, '12, Waterbury
Veal, W. T., Jefferson, '12, Stonington
Verdi, W. F., M.A., (Hon.), Yale, '14, Yale, '94, New Haven
Vernlund, C. F., B.S., S. Dak. State, '09, Harvard, '14, Hartford
Vernon, S. B.S., C. City N.Y., L.I. Coll. Hosp., '30, Willimantic
Vershbow, N., Tufts, '19, Hartford
Vestal, P. W., Phar. D., Geo. Wash., '15, Harvard, '22, New Haven
Vickers, J. L., B.A., Johns Hopkins, '19; M.S., Univ. Wisc., '21, Johns Hopkins, '24, Greenwich
Vollmer, J. W., Yale, '06, Norwalk
Wadhams, S. H., Yale, '96, Torrington
Wadsworth, G. L., B.A., Univ. of Oregon, '32, Univ. of Oregon, '35, Howard, R. I., (Middlesex Co.)
Wadsworth, R. F., B.A., Vassar, '09, M.A., Columbia, '12, Cornell, '19, New Canaan
Wagner, C. P., B.S., Univ. Neh., '26, Univ. Neb., '28, Portland
Wagner, R. L., McGill, '35, A.B., Stanford, '30, Hartford
Waite, R. L., Ph.B., '05, Johns Hopkins, '09, Hartford
Wakeman, E. T., B.A., Yale, '19, Yale, '22, New Haven
Wales, F. J., N.Y.U., '97, Stepney Depot
Walker, R., B.S., Yale, '32, Univ. of Rochester, '37, Cornwall
Walker, W. B., Ph.B., Yale, '16, Yale, '20, Cornwall
Walker, W. H., Harvard, '03, Newtown (Hartford Co.)
Wallace, C. K., M.B., C.M., Queen's, '13, Queen's, Hartford
Wallace, V. G. H., Edinburgh, '26, Norwalk
Walsh, J. F., P. & S., N.Y., '19, Bridgeport
Walton, L. L., Univ. Richmond, '29, Johns Hopkins, '33, Hartford
Ward, J. W., P. & S., Balt., '07, South Glastonbury
Ward, L. S., Cornell, '31, Niantic
Warner, C. N., Jefferson, '96, Litchfield
Warner, C. H., Jr., A.B., Colgate, Tufts, '36, Litchfield
Warner, G. H., Yale, '97, Bridgeport
Warren, E. W., B.A., Yale, '32, Yale, '36, New Haven
Warren, H. F., B.A., Texas Christian, '10, Vanderbilt, '15, New London
Warring, H. L., B.S., Howard, '25, Howard, '28, Hartford
Washburn, W. J. B.S., Indiana, Indiana, '21, Stamford
Waskovitz, D., B.A., Yale, '18, Yale, '20, New Britain
Waterman, C., McGill, '05, Portland, (New London Co.)
Watson, W. J., B.S., Dartmouth, '28, Univ. & Bellevue, '31, Philadelphia, Pa. (Hartford Co.)
Watts, J. F., Georgetown, '12, Bridgeport
Weadon, W. L., Univ. Coll. Med., '05, Bridgeport
Weaver, B. S., Mich., '10, Stamford
Webber, E. R., Jefferson, '14, Waterbury
Weed, F. A., Albany Med., '12, Torrington
Wehger, R. T., B.S., Conn. State, '27, Yale, '32, Bridgeport
Weidman, W. H., Ph.B., Brown, '26, McGill, '31, Norwich
Weil, A., Univ. & Bellevue, '14, New Haven
Weiner, J. G., B.S., Trinity, '25, Yale, '29, Hartford
Weinstein, N., B.A., Trinity (Dublin), '34, Norwalk
Weise, E. C., Jefferson, '20, Bridgeport
Weisenfeld N., B.S., Yale, '24, Univ. Md., '28, Hartford
Weisenborn, W., A.B., '28, B.S., '29, Univ. Kansas, Johns Hopkins '32, Hartford
Welch, H. L., B.A., Yale, '94, Yale, '97, New Haven
Welch, T. F., Georgetown, '04, Hartford
Weld, S. B., B.A., Dartmouth, '12, Harvard, '16, Hartford
Weldon, E. B., P. & S., Balt., '13, Bridgeport
Wellington, H. W., P. & S., N.Y., '13, New London
Wells, D. B., B.A., Yale, '07, Johns Hopkins, '12, Hartford
Wener, W. V., C.M., McGill, '27, Norwich
Wentworth, J. A., B.A., Bowdoin, '09, Harvard, '13, Hartford
Wersebe, F. W., N.Y.U., '98, Washington
Whalen, E. J., Yale, '08, Hartford
Wheatley, L. F., Tufts, '03, New Haven
Whipple, B. N., Yale, '07, Bristol
Whitcomb, B. B., B.A., Bowdoin, '30, McGill, '35, New Haven (Hartford Co.)
White, B. V., Princeton, '20, Harvard, '34, Hartford
White, J. C., B.S., Harvard, '25, Harvard, '29, New Britain
White, W. B., Louisville, U., '12, Stamford
Whitford, W., B.S., Syracuse U., '21, Syracuse U., '22, Windsor Locks
Whiting, H., St., J., McGill, '21, Middletown
Whiting, L. C., Md., Med., '12, New Haven
Whittemore, E. R., B.A., Yale, '98, P. & S., N.Y., '02, New Haven
Whittles, L. J., B.S., Columbia, '17, P. & S., N.Y., '21, Glastonbury
Whitty, C. A., Queen's, 29, Hartford (New London Co.)
Wiedman, O. G., Univ. Pa., '05, Hartford
Wieler, H. J., B.A., Allegheny, P. & S., N.Y., '28, Lakeville
Wienski, J. C., Hahn., Phila., '21, Hartford
Wies, C. H., B. S., M.I.T., '27, Yale, '32, New London
Wies, F. A., B.A., Yale, '29, Yale, '33, New Haven
Wight, W. E., B.A., Bowdoin, '17, Bowdoin, '20, Thomaston
Wilcox, L. N., A.B., Brown, Tufts, '33, Terryville
Wilder, E. A., B.A., Radcliffe, '19, B.Ch., Boston U., '22, Boston U., '23, Middletown
Williams, C. M., P. & S., N.Y., '98, Stonington
Williams, E. E., B.S., St. Lawrence Univ., '19, P. & S., N.Y., '23, Naugatuck
Willner, O., Univ., Vienna, '05, New Haven
Wilson, C. C., B.P. Ed., Springfield Coll., '17, Yale, '28, Hartford
Wilson, F. E., Univ. Vt., '11, New London
Wilson, G. C., B.A., Univ. Okla., '23, Yale, '28, Wallingford
Wilson, H. M., B.A., Univ. Ill., '27, Washington, '27, New Haven
Wilson, J. A., Jefferson, '19, Meriden
Wilson, J. C., Univ. Vt., '04, Hartford
Wilson, L. E., Univ. Vt., '28, Stamford
Wilson, W. A., Louisville, U., '28, Hartford
Wilson, W. R., B.A., Kentucky, '21, Johns Hopkins, '25, New Haven
Winkler, A. W., Harvard, '31, New Haven
Winne, W. N., N.Y.U., '97, New Haven
Winternitz, M. C., B.A., Johns Hopkins; M.A., Yale, Johns Hopkins. '07, New Haven
Winter, H. W., B.S., Yale, '25, Johns Hopkins, '29, Bristol
Winters, J. T., B.S., Catholic U., '27, Univ. Pa., '31, West Hartford
Winter, S., Baylor, '20, New Haven
Witter, O. R., P. & S., N.Y., '01, Hartford
Wolfson, D., B.S., Boston U., Boston U., '33, Bethel
Wood, F. O., B.A., Baylor U., '27, Rush, '31, Hartford
Woodford, C. N., Louisville, U., '08, Hartford
Woodford, C. N., Louisville U., '08, Hartford
Woodford, F. B., Ph.B., Yale, '18, Yale, '24, Ridgefield
Woodruff, T. A., McGill, '88, New London
Woodson, J. T., B.A., Vanderbilt, '15, P. & S., N.Y., '20, Hartford
Woodward, H. B., B.S., Wesleyan, '08, Johns Hopkins, '12, Bristol (Litchfield Co.)
Woodward, J. C., Columbia, '35, New London
Worthen, T. W., Dartmouth, '11, Hartford
Wrang, W. E., Jefferson, '19, Middletown
Wray, E. H., Jr., Ph.B., Yale, '23, Yale, '32, Litchfield

Wright, W. W., B.A., Yale, '12, Harvard, '19, Hartford
Wulp, G. A., B.A., Princeton, '19, Univ. Mich., '30, Hartford
Wurtenberg, W. C., Ph.B., Yale, '89, Yale, '93, New Haven
Yannet, H. B.S., C. City of N.Y., '25, Yale, '29, New Haven
Yavis, J. C., Univ. Athens, '18, New Haven
Yeager, C. F., B.S., Hahn., Phila., '33, Bridgeport
Yergason, R. M., P. & S., N.Y., '09, Hartford
Yost, O. R., Virginia, '30, Hartford
Young, W. G., Univ. of Toronto, '30, Hartford
Yudkin, A. M., Ph.B., Yale, '14, Yale, '17, New Haven
Zaglio, E. R., A.B., P. & S., N.Y., '30, P. & S., N.Y., '33 Manchester
Zariphes, C. A. P., B.S., Boston U., '22, Boston U., '24, Hartford
Zaur, I. S., B.S., Yale, '29, Yale, '32, Bridgeport
Zeman, B., Ky. Med., '08, Hartford
Zimmerman, H. M., B.S., Yale, '24, Yale, '27, New Haven
Zweben, A., Middlesex, '22, South Norwalk

⁂

CEREVIM INTRODUCES A NEW PRODUCT "BETAMIN"

(Thiamin Wafers)

A delicious and rational method of administering Vitamin B1 orally. Each wafer contains 100 International Units (.3 mg.) of Vitamin B1 and is low in caloric value (15 calories per wafer). Excellent for restricted diets or whenever a Vitamin B1 deficiency is indicated. Children particularly, will appreciate this delicious wafer.

Issued in hermetically sealed tins (approx. a thirty day prescription) and available at leading pharmacies.

Accepted by the Council on Foods of The American Medical Association.

Mail your prescription blank today for professional samples and literature.

Cerevim Products Corporation, 100 Sixth Avenue, New York, N. Y.

ITS QUICK ACTION PREVENTS DEFORMITIES

No antiricketic substance will completely straighten bones that have become grossly misshapen as the result of rickets. But Oleum Percomorphum can be depended upon to prevent ricketic deformities if given early and in adequate dosage. This is not true of all antiricketic agents, many of which are so limited by tolerance or bulk that they cannot be given in quantities sufficient to arrest the ricketic process promptly, with the result that the bones are not sufficiently calcified to bear weight or muscle-pull and hence become deformed.

Malpractice — Radium
All Risk Instrument

Aetna and Affiliated Companies

R. C. Knox & Company
125 Trumbull Street Tel. 2-0206
HARTFORD, CONNECTICUT
We Sell All Forms of Insurance

You must be getting ready for Children's Day, Dr. Brown, buying all this Chewing Gum.
Keeping Chewing Gum in my office is a fine way to build good will, Mac, because both youngsters and grown-ups appreciate it when you offer it to them.
A suggestion for you, Doctor—on how to build good will
THE CHEWING GUM WAY
U-187

Offering Chewing Gum to young patients is a very friendly thing to do, and you can be sure of a ready, pleasant response to it.

Enjoy Chewing Gum yourself, Doctor. It's just right-sized to carry conveniently in your pocket.

THE NATIONAL ASSOCIATION OF CHEWING GUM MANUFACTURERS, STATEN ISLAND, NEW YORK

LIST OF SUCCESSFUL APPLICANTS WHO APPEARED BEFORE THE CONNECTICUT MEDICAL EXAMINING BOARD ON JULY 9, 10 AND 23, 1940

Vincent Cacace — 835 Fairfield Ave. Bridgeport, Conn.
Leonard A. Howard — 199 White St. Danbury, Conn.
James L. Flynn — 35 Asticou Road, Forest Hills, Boston, Mass.
William A. Donnelly — 2618 Main St. Bridgeport, Conn.
Lisbeth Fink — 4719 Fort Hamilton Parkway, Brooklyn, N. Y.
Oscar Roth — St. Raphael's Hosp. New Haven, Conn.
Irwin S. Eskwith — 166 Grovers Ave. Bridgeport, Conn.
Ludovic V. Claps — 45 Couch St. So. Norwalk, Conn.
Aaron Bobrow — 46 Lenox St. Hartford, Conn.
Samuel R. Millen — Grace Hosp. New Haven, Conn.
Harry L. MacKinnon — 202 Washington St. Hartford, Conn.
Jason O. Burack — Norwalk General Hosp. Norwalk, Conn.
Edward P. Cutter — Main St. Wallingford, Conn.
Edwin F. Trautman — 33 Truman St. New Haven, Conn.
Heinz W. Markwald — 135 Mansfield St. Hartford, Conn.
Philip S. Brezina — 178 Mountain Road, West Hartford, Conn.
John C. Haley — Box No. 66, Mt. Carmel, Conn.
Rogers N. Ryley — Mystic, Conn.
Robert W. Biach — 333 Cedar St. New Haven, Conn.
John W. Bick, Jr. — 200 Retreat Ave. Hartford, Conn.
William A. Bryan — Norwich State Hosp. Norwich, Conn.
John C. Cunningham — 635 West 165 St. N.Y.C.
Louis A. Erskine — New Haven Hosp. New Haven, Conn.
Thomas M. Feeney — 78 Marine Road, Boston, Mass.
Irwin Felsen — 1106th Company, Torrington, Conn.
Sidney Feyder — New Haven Hosp. New Haven, Conn.
William Goodrich — 3120 Fairfield Ave. Bridgeport, Conn.
Max Hayman — 200 Retreat Ave. Hartford, Conn.
Derick A. January — 165 Terry Road, Hartford, Conn.
Leon Kaplan — 1725 Morris Ave. Bronx, N.Y.
William H. Lowell, Jr. — Mass. General Hosp. Boston, Mass.
Raymond A. Martin — Morrisanis City Hospital, N.Y.C.
Donald W. Oelker — Greenwich, Conn.
William L. Peltz — 158 Whitney Ave. New Haven, Conn.
Alfred Ring — City Hosp. Welfare Island, N.Y.C.
George E. Roberge — New Haven Hosp. New Haven, Conn.
Thomas A. Rourke — 1425 University Ave. N.Y.C.
Joseph Sklaver — 56 Hawkins St. New Britain, Conn.
Rebecca Z. Solomon — 294 Colony Street, Meriden, Conn.
Stuart S. Stevenson — Old Post Road, Fairfield, Conn.
Frederick C. Weber, Jr. — 25 West Elm St. Greenwich, Conn.
Sylvia Weiner — 29 Elmer St. Hartford, Conn.
John Hall Wentworth — 240 Oliver Road, New Haven, Conn.

Prescribed for the Professional Palate

There's no whisky to please your palate more completely than Johnnie Walker. For there's no finer whisky than Scotch, and Johnnie Walker is Scotch at its smooth, mellow best.

IT'S SENSIBLE TO STICK WITH
JOHNNIE WALKER
BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820
... still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE

Wyeth

is indicated in the treatment of

★ Acute Anterior Urethritis (due to Neisseria gonorrheae)

★ Trichomonas Vaginalis Vaginitis

★ Vaginal Moniliasis

★ Bartholinitis and Skeneitis (due to Trichomonas Vaginalis)

Silver Picrate is a definite crystalline compound of silver and picric acid. Available in the form of crystals and soluble trituration for the preparation of solutions; suppositories; water-soluble jelly; and powder for insufflation.

Complete information mailed on request

★ JOHN WYETH & BROTHER, INCORPORATED ★

PHILADELPHIA, PA.

WOMEN'S MEDICAL COLLEGE OF PENNSYLVANIA

Dr. Margaret D. Craighill has been appointed Acting Dean of the College and will begin her duties September 16, 1940.

Dr. Craighill received her B.A. and M.S. degrees at the University of Wisconsin and her M.D. at Johns Hopkins in the Class of 1924. After an internship in Gynecology and Surgery at Johns Hopkins Hospital, she spent a year as Assistant in Pathology at Yale Medical School. She was Assistant Resident in Gynecology at Johns Hopkins Hospital from 1926-1928, and for six months was Assistant Radiologist at the Howard A. Kelly Hospital, Baltimore, Maryland.

Since 1928 Dr. Craighill has been engaged in private practice in Gynecology and Obstetrics in Greenwich, Connecticut, where she is Attending Gynecologist at the Greenwich Hospital.

She is a member of Phi Beta Kappa, a Fellow York Academy of Medicine, and a Diplomate of the American Board of Obstetrics and Gynecology.

SQUIBB RELEASES SULFATHIAZOLE

Sulfathiazole has been released for sale by E.R. Squibb & Sons, New York, in the form of 0.5 gram scored tablets for oral dosage and in crystals for compounding prescriptions and for determination of blood concentration.

Sulfathiazole has received extensive clinical trial and is a noteworthy advance in the chemotherapeutic treatment of pneumococcal and staphylococcal infections. It is the third of the "sulfonamide derivatives" to be released for sale by Squibb, the others being Sulfanilamide and Sulfapyridine. Sulfathiazole is believed to have the following advantages over Sulfapyridine.

1. More uniform absorption.
2. Less conjugation after absorption, so that a higher proportion of the total drug in the body-fluids is chemotherapeutically active.
3. Less tendency to cause serious nausea or vomiting.
4. Greater effectiveness against staphylococcal infections.

Sulfathiazole Squibb is supplied in bottles of 50, 100 and 1,000 0.5 gm. tablets and 5 gm. vials of crystals.

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN:

Connecticut State Medical Society (1940-1941) . 4
Connecticut Hospital Association (1939-1940) . 5

ORIGINAL PAPERS:

Medicine and Medical Care in the Defense Program —
A memorandum prepared for His Excellency Governor Raymond E. Baldwin by the Connecticut State Medical Society, September 1940 586
Connecticut Prepares . . . . . Sanford H. Wadhams, Torrington, Conn. 588
Physiology of Aviation and Medical Preparedness — J. F. Fulton, M.D., New Haven, Conn. 590
Aviation Medicine Today . . . . William B. Smith, M.D., Hartford, Conn. 595
Medical Aspects of Deep Sea Diving — C. W. Shilling, Lt. Com., Med. Corps, U. S. Navy 597
Increasing Importance of Preventive Industrial Medicine — Albert S. Gray, M.D., Hartford, Conn. 600
MESSAGE FROM THE PRESIDENT OF CONNECTICUT STATE MEDICAL SOCIETY — Arthur B. Landry, M.D., Hartford, Conn. 605

ABSTRACTED PAPERS:

Blast Injuries to the Lungs 603
Body Protection for the Soldier 621

EDITORIALS:

Medical Preparedness 606
From Peace To War . . . 607
Approach to Early Diagnosis of Malignancy in Genito-Urinary Tracts 608
American Red Cross-Harvard Study Unit 609
Doctor Burt Presides 609
National Hearing Week 609
Military Medicine Number of Other State Journals . . . 610
Lady Drivers (For Home Consumption) 610
FROM THE SECRETARY'S OFFICE . . 611
PROGRAMS — SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS . . . 613
CONNECTICUT HOSPITAL ASSOCIATION 614

MEDICAL PREPAREDNESS NEWS:

National Conference on Medical Preparedness 619
Refugee Children in United States . . . 622
Medical Preparedness in Other States . 623
Medical Profession Prepared for New Conscription Act 625
Evacuation Scheme of Children in England . . 626
THE DOCTOR'S OFFICE 626
GENERAL PRACTITIONER'S FORUM 627
OUR NEIGHBORS 627
NEWS FROM COUNTY ASSOCIATIONS 628
SPECIAL NOTICES 631

OBITUARY:

Hans Zinsser, M.D. . . . . S. Bayne-Jones 632
QUARTO NOTES (Book Reviews) 633

NEW DRUGS

that are not new

New therapeutic agents marketed under the Lilly label are not new to their maker. Products of the Lilly Laboratories have always had a substantial background of laboratory and clinical study before being released for general use.

ILETIN (INSULIN, LILLY)

an aqueous solution of the antidiabetic principle, was the first preparation of Insulin commercially available in the United States. Years of research and experience in the manufacture of large lots of Iletin (Insulin, Lilly) assure its purity, stability, and uniform potency.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES • INDIANAPOLIS, INDIANA, U. S. A.

The Connecticut State Medical Journal

Vol. IV. OCTOBER, 1940 No. 10

HAVE YOU RETURNED

THE A. M. A. QUESTIONNAIRE ON MEDICAL PREPAREDNESS?

Connecticut Ranks Twelfth in Replies Received

Nebraska	88.3 per cent
Arizona	87.
Canal Zone	86.6
Kentucky	83.4
North Dakota	83.
Minnesota	80.7
Utah	73.2
Iowa	73.
Washington	68.7
South Dakota	68.5
Indiana	67.1
Connecticut	65.

Blank forms may be obtained from the society office

528 CHURCH STREET NEW HAVEN, CONN.

TELEPHONE 5-0249

Medicine and Medical Care in the Defense Program

A memorandum prepared for
His Excellency Governor Raymond E. Baldwin
by The Connecticut State Medical Society
September 1940

The national health takes on new significance as a powerful military weapon. Man power and machines are the things that are to be counted on, but underlying them both is the physical and mental well-being of the people. The organized medical profession of America realized and accepts its responsibilities.

The Connecticut State Medical Society numbers among its members more than eighty per cent of the physicians in the State and willingly offers its resources and organization to be integrated with the State's preparedness effort.

Early in June of this year the Surgeon General of the United States Army, acting in cooperation with the Surgeon General of the Navy and of the Public Health Service, asked the American Medical Association to establish a national committee on medical preparedness. This was speedily accomplished and the committee is in operation. The administrative organization consists of this national committee of fifteen under the chairmanship of Doctor Irvin Abell, Louisville, Kentucky, a former president of the American Medical Association, and a chairman on medical preparedness in each State. Doctor George Smith of Pine Orchard is the chairman for the State of Connecticut and the pattern of organization within the State has been completed with a State committee consisting of a member from each of the eight counties who will act as the chairman on medical preparedness for his county.

The personnel of the State organization is as follows:

Chairman: George M. Smith, Pine Orchard. Medical Director of the Scovill Manufacturing Company, Waterbury; Consulting Surgeon, St. Mary's Hospital; member of the National Advisory Cancer Commission, Washington, D.C.; Medical Officer, American Expeditionary Forces 1917-1919.

The President of the Connecticut State Medical Society: Arthur B. Landry, Hartford. Consulting Physician, St. Francis Hospital; Medical Officer, Connecticut National Guard; Medical Officer, American Expeditionary Forces 1917-1919.

The Secretary of the Connecticut State Medical Society: Creighton Barker, New Haven. Medical Officer, American Expeditionary Forces. Former Medical Inspector, 43rd National Guard Division.

Fairfield County: H. Bertram Lambert, Bridgeport. Surgeon, Bridgeport Hospital; Medical Officer, United States Navy 1917-1919.

Hartford County: Donald B. Wells, Hartford. Surgeon, Hartford Hospital; Medical Officer, American Expeditionary Forces 1917-1919.

Litchfield County: Francis A. Sutherland, Torrington. Surgeon, Charlotte Hungerford Hospital; Medical Officer, General Hospital 39 (Yale Unit).

Middlesex County: George A. Elliott, Middletown. Assistant Superintendent, Connecticut State Hospital; 46th Battalion, Infantry, Canadian Expeditionary Forces 1916-1919.

New Haven County: Ralph E. McDonnell, New Haven. Secretary, New Haven County Medical Association; Dermatologist, New Haven Hospital.

New London County: Daniel Sullivan, New London. Surgeon, Lawrence and Memorial Hospital.

Tolland County: Donald M. Beckwith, Rockville. Physician, Rockville Hospital.

Windham County: Edward J. Ottenheimer, Willimantic. Surgeon-in-Chief, Windham Community Memorial Hospital; Medical Officer, General Hospital 39 (Yale Unit).

At this point the medical preparedness program in Connecticut is directed toward fulfilling the following needs:

Medical Personnel

The classification of the physicians in the State and consideration of their qualifications and availability for military training and service. This is a part of the personnel study being made by the American Medical Association for the Surgeon General of the Army and which is considered to be the first objective of the national medical preparedness program.

Selective Service

Full cooperation with the civil and military authorities of the State of Connecticut in providing medical personnel for the administration of a selective service law.

Public Health

Cooperation and consultation with the State Commissioner of Health in formulating and carrying out the State's Public Health program extended to meet conditions arising with the preparedness and defense activities in the State.

Health in Industry

Studies and understanding of medical problems arising in expanded war time industries within the State. This will be done in cooperation with the Bureau of Industrial Hygiene of the State Department of Health and through already existing conference committees on industrial health in the State Medical Society, the Connecticut Manufacturers' Association and the Connecticut Chamber of Commerce. The State Medical Society will also make available its organization and personnel in furthering the contemplated enterprise of Yale University in the establishment of an industrial training unit under federal military direction.

Civilian Medical Care

Study and review of the available facilities for the medical care of the civilian population in order that this necessary service may be carried on with the least possible disarrangement. In this connection the State Medical Society is prepared to avail itself of the advice and assistance of the Connecticut Hospital Association, the State Nurses Association and the State Pharmaceutical Association through already existing joint conference committees.

Emergency Plans

Study, under the guidance of the State military, police and transportation authorities, of means to provide the necessary medical care and protection of the civilian population in emergency and in the event of forced evacuation.

As time goes on events may shape the necessity for additional considerations in the field of medical care and the protection of our citizenry. The Connecticut State Medical Society is prepared to meet these demands and accept the directive of the government of this State.

—☆☆—

A.M.A. MEDICAL PREPAREDNESS SURVEY 52 PER CENT COMPLETE ON SEPT. 6

"On September 6 the Committee on Medical Preparedness (of the American Medical Association) had received 93,437 schedules from physicians throughout the United States and its outlying territories. This number represents 52 per cent of the 179,796 schedules which were mailed to physicians in July," *The Journal* of the Association reports in its Medical Preparedness Section for Sept. 14.

"The response of physicians in different states showed a wide variation, from 83.2 per cent in Nebraska and 85.8 per cent in the Canal Zone to 38.5 per cent in New Mexico and 0.08 per cent in the Philippine Islands. Thirty-eight states showed more than 50 per cent of questionnaires returned.

"Now that the vacation season is nearing its close, some physicians may be expected to return the schedules which have been awaiting their return.

"Changes of address should be reported promptly to the Directory Department of the American Medical Association so that the Committee on Medical Preparedness can supply schedules to physicians who could not be reached on the first mailing.

"The first 50 per cent of returns represent a prompt and willing response from the physicians in all parts of the nation. It is earnestly hoped that the second fifty per cent will respond without delay."

Connecticut Prepares

SANFORD H. WADHAMS, Chairman
Connecticut Joint Executive Defense Committee

Just a year ago, Great Britain and France went to war with Germany. In an incredibly brief period of time Germany had overrun Poland and destroyed her army. During the following winter months the combatants manned defense positions with little in the way of active military operations. During this period we heard much of what was referred to as a "phoney" war.

In this country we generally viewed the situation with complete complacency. We were told on all sides that we had only to keep away from the countries at war and we had nothing to fear; that the Atlantic Ocean was, and always had been, complete protection. Few at that time looked beneath the surface sufficiently to realize that the Atlantic Ocean was a protection only so long as it was controlled by a friendly power. Fewer still, it would appear, realized that Great Britain since the time of Monroe had been responsible for our protection on the Atlantic seaboard.

Suddenly, in the spring, the war of inaction came to an end. Norway, Denmark, and Holland were invaded and absorbed by the Reich, and then followed the complete subjugation of Belgium and France. Almost overnight it now seems, we in the western hemisphere realized that we had been living in a fool's paradise. What it would mean to our country if control of the Atlantic Ocean should fall into the hands of a hostile power or combination of powers, suddenly dawned upon us. We found that we had an army insufficient in numbers, almost totally lacking in all types of modern equipment and unsupported by what we had suddenly appreciated had become a vital means of defense—an air service. We learned that we had a strong navy but that it was a one ocean navy, planned, equipped and supplied with bases on that assumption.

Congress hastily voted huge sums of money to supply military equipment, only to waste precious weeks in deciding how to provide the necessary manpower. The urgent need for material preparedness is generally appreciated, but we have heard little of the even greater need for moral and spiritual preparedness if our people are to meet the sacrifices which lie ahead.

One of the first to appreciate the gravity of the situation was Governor Baldwin. Several months ago, he began to study the problem of preparedness as it directly affects the State of Connecticut. His first step was to appoint a State Council of Defense of which he is Chairman. The members are prominent in various walks of life and specially fitted to counsel and advise on Connecticut's defense program. As none of the members holds state office they have no statutory authority.

The next step taken by the Governor was to appoint a Cabinet, all of the members of which are elective or appointive officials of the State and therefore have authority in their respective fields. Having established the Council and Cabinet, he then named a Joint Executive Defense Committee composed of three members from each group. Upon this committee falls the duty of developing and coordinating the State's defense program, both within the State and with the National Defense Council.

More recently, the Governor has requested the First Selectman of each Town and the Mayor of each city to appoint a Local Defense Committee, this to ensure coordination of local effort with the State and National program. Already a considerable number of such Committees has been formed and more are being reported daily. It is the hope of the State Defense Committee that it may advise and assist the local committees in carrying out the general plan of the National Council of Defense.

Amongst the multitude of problems which are inseparable from a National Defense program there are certain ones which plainly fall within the scope of the Federal government and for the solution of which legal authority exists. Another large group, it is apparent, are responsibilities of the States. In addition, there is a third group not included, in so far as the State is concerned, in the statutory responsibilities of any existing State department or agency. It is this last group with which the State Defense Committee must more particularly concern itself. If Connecticut is to measure up to its important part in the national defense program, it must have the wholehearted support of every element in our complex society.

The prompt and decisive action of the medical profession in listing and classifying in appropriate groups all the physicians in the country ensures that this time this professional group, so completely essential to the successful conduct of warfare, will not be handicapped as was the case in the last war. It can be confidently anticipated that the people of the nation, not only those in the military service, but all the people will, regardless of what lies before us, receive the best of medical care.

⁂

WAR AND MEDICINE

The World War, while it put a quietus on a certain sort of medical research then in progress, on the whole did more for the advancement of medical knowledge than any other one single factor within the last generation. The war was of tremendous educational value to doctors. It sent thousands of them to school again, presented them with new problems and challenged the best that was in them and in the medical profession as a whole.

The war presented the opportunity for the mass study of rare and hitherto poorly understood diseases. The Flanders epidemic of infective jaundice was identified with a similar outbreak in Japan and shown to be due to the Leptospira icteroides. Para-typhoid fever was recognized more frequently than ever before. Cerebrospinal meningitis became epidemic both in England and in this country, and advances were made particularly in an appreciation of its epidemiology and the significance of early bacteremia. The pandemic of influenza stimulated an enormous amount of investigative work of lasting value. Scurvy in Iraq, typhus in Servia, deficiency diseases in Central Europe, dysentery in the Gallipoli Peninsular, trinitrotoluene poisoning in munitions workers and tetrachlorethane poisoning among aeroplane makers, epidemic encephalitis, trench fever and nephritis constituted an array of old diseases in new guises, as well as diseases never before recognized, which served as a constant stimulus to medical acumen.

Nor should we forget the field of mental disease where shell shock, for example, afforded the opportunity of testing the validity of some of the Freudian theories of morbid psychology based on mental conflicts and the repression of painful experiences. It is doubtful if there was a single specialty of medicine which did not derive some benefit from the experiences of the war. Certainly cardiology did. Orthopedics did. Surgery did. In fact, neurosurgery had its birth at this time and many of the best known specialists in this field today acknowledge the war as an impetus that propelled them into their present work.

On all sides it is being asked what new facts of interest to medicine have been developed in the present war. What type of wounds are being encountered? Is shell shock more or less frequent? What has been learned of the new science of the hygiene of aeronautics? Can human mechanism stand the terrific speed of the modern planes, the violent changes of atmospheric pressure that result when it is hurtled through space, now up, now down, and the intense nervous strain of acute fear and chronic anxiety?

In the bureaus of statistics, convalescent camps and hospitals for the care of the permanently disabled which will follow in the wake of this war, the answer will be found by some future student of the subject.

Edit., Va. Med. Monthly, Aug. 1940

NEW PRODUCT:

The Professional Equipment Company of New Haven is now demonstrating the new Keleket portable x-ray machine for office and home use. It has a capacity of 15 MA at 80 KV. New features include a twenty-four step auto transformer, and a direct reading kilovolt meter. It is carried in three cases of less than forty pounds each. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

(SEE PAGE 2.)

Physiology of Aviation and Medical Preparedness

J. F. FULTON, M.D.,
New Haven, Conn.*

It has now become obvious that the titanic struggle proceeding at this moment between the democracies and the totalitarian states will in all probability be won in the air; for so long as the Royal Air Force can hold its own against the air squadrons of Germany and Italy, England cannot be invaded from the sea.

The factors which have contributed to the enormous advance in military aviation during the past twenty-five years, and more especially during the past ten years, have been in the realm of physiology quite as much as in the physical principles of airplane design, and it is highly important for anyone considering problems of medical defense to be familiar with the basic principles, as well as with the newer developments in aviation physiology. The later developments have recently been described in an admirable book entitled *Principles and practice of aviation medicine*[1] by Captain Harry G. Armstrong, Director of the Aero-Medical Research Laboratory of the United States Army at Dayton, Ohio. It first appeared in December 1939 and is now being reprinted. Armstrong's book is the best general text in English on this vitally important subject.

General Principles

When Robert Boyle made his first suction pump back in 1659, he observed that a glass container after its air is withdrawn is lighter in weight than the same glass container when occupied by ordinary air. He concluded from this that the air has weight and that the weight of the air surrounding the earth is sufficient to support a column of 29 inches of mercury. As he gradually withdrew the air from the chamber, he observed that it would support less of the mercury column, and he insisted that this "rarefied" air was similar to that encountered on high mountains. He found that it supported a flame less well than the air at sea level.

On the basis of these observations, Robert Boyle made the brilliant deduction that the air at sea level is more compressed on account of its physical weight, and that on high mountains the air is less compressed because there is less air above to weigh it down. But Boyle went further than this, since, when he gradually withdrew the air from his decompression chamber, he found that a candle ceased to burn at approximately the same time that the air became unable to support the life of a bird or a mouse, and he concluded that there was something in common between the "flame of life" and the flame of a burning candle — something extracted from the air essential to them both.

Finally, Boyle observed (1660)[2] in the eyes and also in the blood vessels of animals which had been subjected to very rapid decompression that bubbles appeared, and he suggested that these bubbles were formed from particles of air which had been absorbed by the blood stream. This was the first description of a phenomenon now of high importance in aviation, namely, "aero-embolism". And so to Robert Boyle we must accord the epithet not only of "father of modern chemistry," but also, and in a very real sense, "the father of aviation medicine."

Dry air is composed of some 20.9 per cent by volume of oxygen, 78.5 per cent nitrogen and ± 1 per cent of the rare gases. When brought into contact with the pulmonary epithelium, these several gases exert a partial pressure which varies with their relative concentration; but in the pulmonary alveoli one is obliged to cope with water vapor of some 47 mm. tension and carbon dioxide which exerts a partial pressure of about 40 mm. — values of great importance, especially at high altitudes. At sea level with the barometer at 760 mm. Hg the gases of water- aturated air would exert the following partial pressures:

---

*Laboratory of Physiology, Yale University School of Medicine.

Oxygen	107
Carbon Dioxide	40
Nitrogen	566
Water vapor	47
	760 mm.

The partial pressure oxygen in the venous blood entering the normal human lung varies between 50 and 60 mm., whereas the carbon dioxide tension is about 46 mm. By a process of simple diffusion, therefore, oxygen would pass from high to points of lower tension. Oxygen is thus taken up by the lungs and carbon dioxide passes outward and is given off.

As one ascends in an airplane, the partial pressure of each of the gases of external air, *i.e.*, oxygen and nitrogen, diminishes whereas the partial pressure of water vapor, carbon dioxide and the oxygen of the venous blood tends to remain constant. The difference between the partial pressure of oxygen in the alveolar air and that in the lungs diminishes progressively, but is still sufficient to maintain life in an adult human being at altitudes of 20,000 to 25,000 feet, at which the barometric pressures are 349 and 282 mm., respectively and the partial pressures of oxygen are 73 and 59 mm. respectively. The partial pressure of oxygen at these altitudes is thus little greater than that of the venous blood. Smaller animals, with more rapid heart and respiratory rates, can survive in altitudes as high as 32,000 feet where the difference in partial pressure of oxygen of the alveoli and blood amounts to only a few millimetres. By breathing oxygen, however, aviators can ascend without developing serious symptoms of oxygen want to altitudes as great as 41,000 feet. At the present time, it is impossible to maintain human life at altitudes greater than this without the use of pressure cabins. At an altitude of 50,300 feet, the atmospheric pressure will be 86 mm., at which level with 47 mm. partial pressure of water vapor and 39 mm. of carbon dioxide, the alveolar oxygen pressure will be zero, and in these circumstances oxygen would actually pass from the blood to the alveolar air.

Special Physiological Problems of Aviation

The bombing operations of the present war are being carried out from prodigious heights partly to avoid anti-aircraft defenses and partly also to increase the speed of movement of bombers when their objectives are many hundreds of miles from their bases. Hence, any physiological advantage which one belligerent may achieve over another may be decisive in determining the outcome of this air conflict. Four aspects of the problem may be discussed separately. They have to do with four types of physiological breakdown experienced by fliers.

Air sickness. This is perhaps the most complex and the least understood of all the forms of physiological breakdown which may occur in the air. It is encountered in civilian air passengers, as well as in aviation pilots, and may occur at low altitudes; hence it probably has little or nothing to do with the basic prolem of oxygenation.

In its acute form air sickness occurs generally in rough weather when there is sudden acceleration in any direction of space with consequent stimulation of the vestibular system. Some individuals seem irrevocably prone to air sickness, much as is true of sea sickness. In certain types of rough weather, even the most hardened pilots become ill, but with any given individual the predisposition to air sickness varies with physiological states of fatigue, emotional status, over-indulgence, especially of alcohol (the morning after). Armstrong has discussed the problem at some length, but he concludes somewhat helplessly that the only two methods of preventing air sickness are bilateral destruction of the labyrinths, or repeated daily turning in a Barany chair for a period of several weeks before taking the flight. It is probable, however, that atropine and other parasympathetic paralysants serve as moderately effective prophylactic measures in susceptible individuals. When a seizure is precipitated at high altitude, anoxia may be a contributing factor and administration of oxygen is indicated.

Anoxia in aviation. Within the past few years, opinion and practice have changed widely with regard to the use of oxygen in aviation. The diminished partial pressure of oxygen experienced in altitudes above 5,000 feet leads to physical inertia, some confusion of thought and those responsible for piloting planes now take oxygen routinely when flying in altitudes above

8,000 or 10,000 feet; in most air lines it is mandatory for the crew to wear oxygen masks when flying above 10,000 feet. When this precaution is not observed, signalling becomes inaccurate, the reaction time of the pilot is increased and after a long flight such as those involved in trans-Atlantic clippers the feeling of headache, lassitude, etc., so well-known to the pilots of the early clipper flights, is intense. Since the routine use of oxygen by transport pilots, these disagreeable sequelae of long flights have become largely things of the past.

But with military aviation, in which the majority of operations occur at altitudes between 15,000 and 30,000 feet, oxygen has become an essential part of the equipment of every plane. This of itself involves an additional hazard, for if an oxygen tank is machine-gunned the oxygen explodes with terrific violence, destroying the crew and the ship. Free oxygen in the cabin is for this and other reasons out of the question because of the combustion and explosion hazards. When breathing pure oxygen from a mask, a pilot may ascend to 25,000 or 35,000 feet without experiencing symptoms referable to oxygen want. Between 35,000 and 41,000 feet, the partial pressure of oxygen, even when breathed in 100 per cent purity, diminishes so rapidly that beyond 38,000 symptoms of anoxia quickly develop; at present there is no physiological means of increasing the height at which a military plane may fly without the use of pressure suits, or the costly stratosphere pressure cabin. This equipment has been used in certain bombers for long range flights, but it has not been thought feasible for fighting planes, since the cabin may be machine-gunned and the pressure relations in that way abruptly disturbed.

Aero-embolism. The high altitude flying of the present war has brought another hazard which has begun to attract wide notice during the past two years, namely, Robert Boyle's phenomenon of a formation of air bubbles in the tissues and blood vessels at high altitude. This is not a new concept in physiology, for the same phenomenon has been encountered in divers and caisson workers when allowed to come from atmosphere of increased pressure to normal atmospheric pressure at too rapid a rate. The state of acute collapse which may supervene, known among divers as "the bends" and also as "caisson sickness," is due to the liberation into the tissues of dissolved nitrogen. The nitrogen bubbles form, in the parenchyma of the central nervous system, in peripheral nerves, and probably also in the bones and joints, thus giving rise to acute pain; if a sufficient mass of these bubbles diffuses in the blood stream and pass to the right heart, the pulmonary circulation is impeded, the blood becomes frothy and acute collapse and death may occur as with ordinary air embolism encountered during surgical operations.

Exactly the same phenomenon occurs in aviators when they subject themselves to a sudden change from atmospheric pressure to an altitude of 30,000 feet, *i.e.*, when they become decompressed from one atmosphere to a third of an atmosphere. The Hurricane and Spitfire planes used by the R. A. F., the Messerschmidts of the German Air Force, and our own fighter planes, can ascend from sea level to an altitude of 35,000 feet in 6 to 10 minutes. Some models under favorable conditions can ascend even more rapidly. A susceptible individual in these circumstances may develop symptoms of a grave character, which tend to appear in the following sequence (See Armstrong, p. 350):

1. **Structural system**
    a. Knee joint pain
    b. Finger joint pain
    c. Shoulder joint pain
    d. Ankle joint pain
    e. Hip joint pain
    f. Others
2. **Dermal system:**
    a. Thermal hyperesthesia
    b. Formication
    c. Pruritus
    d. Neurodermatitis
    e. Urticaria
3. **Cerebrospinal system:**
    a. Neuritis
    b. Paralysis
    c. Convulsion
    d. Coma
4. **Respiratory system:**
    a. Pulmonary pain
        1. Pulmonary pain
        2. Stabbing
    b. Pulmonary edema
    c. Cough
    d. Expectoration

The clinical syndrome may develop suddenly and prove completely incapacitating to a pilot.

However, the experienced flier recognizes the onset of joint pains and with this warning quickly descends to a lower altitude. This, as a rule, causes the symptoms to disappear, but in the acute cases symptoms may increase rather than otherwise with initial descent, and the individual, if successful in landing his plane, may be so incapacitated from the experience as to be unable to fly for many weeks. He loses his "ceiling" and if he ascends soon after the experience symptoms may recur at a much lower altitude. Although the symptoms themselves have been attributed largely to aero-embolism, it is obvious that anoxia may also play a part, since at altitudes above 35,000 feet it is impossible to maintain the partial pressure of oxygen sufficiently high for adequate oxygenation of the tissues. Experimental studies are being undertaken in various centers on the problem of aero-embolism, in the hope of sorting out the symptoms due primarily to bubble formation from those resulting from anoxia.

Much attention has also been given to the problem of preventing aero-embolism or "decompression sickness" (as it should more properly be called). Since it is known that the bubbles come, not from oxygen, but from dissolved nitrogen, any preliminary procedure which would cause the body to blow off its dissolved nitrogen is indicated. Thus, if an animal is caused to breathe pure oxygen for a period of some hours before ascent it is able to withstand altitudes of 40,000 feet with greater physical comfort than an animal which has not had previous oxygenation. This is a direct application of principles long known with regard to caisson sickness, but with aviators who are on call and who must ascend within two or three minutes of call it is obviously not a practicable procedure. However, if they breathe oxygen immediately they leave the ground they are better able to adjust to extremes of altitude than if they defer taking oxygen until reaching 10,000 or 12,000 feet. The subject, however, urgently needs further investigation.

Physiology and the power dive. One of the most effective devices of modern air warfare has been power dive. Not only does it serve to bring a flier quickly from the site of danger, but in certain types of bombing operation it gives him aim of an almost devastating accuracy; indeed, it is the power dive with the accuracy and attendant enormous velocity that is the basis for the belief that the air bomber may become in the long run more significant as a defense weapon than the naval arm of modern defense.

But power dives have limitations that reside, not within the ship itself, but within the human organism operating the plane. From an altitude of 25,000 feet, a modern fighting plane can achieve in a vertical power dive velocities of 600–700 miles an hour, or a velocity of 12 to 13 times that normally achieved by a falling body impeded by the friction of air resistence. During such a dive the body of the pilot is horizontal. After the bomb is dropped, the plane must turn out of the vertical fall and again proceed in parallel with the earth's surface. During the turn the body of the aviator becomes once more vertical, but the centrifugal force carries all his movable fluids from the head toward the feet, with the result that the aviator experiences what he calls a "black-out". Everything becomes black, vision and hearing are abolished and consciousness may be lost for periods varying from a few seconds to several minutes, depending upon the velocity and the sharpness of the turn. Aviators have long been aware that shouting and tightening of the collar when turning out of a dive tend to prevent the black-out and loss of consciousness, since this tends to prevent the flow of blood away from the head. But even with lusty shouts and vigorous squeezing of the jugulars, the average pilot cannot be certain of coming successfully out of a dive when his acceleration is more than 5 G, *i.e.*, 5 times the normal acceleration of gravity. Hence, in bombing operations it is now mandatory in the air services that the power dive shall not exceed 5 G in velocity.

The air service which first devises a physiological means of preventing the precipitate flow of blood from the head at the end of a power dive will obtain a strategic advantage of incalculable value in the present air struggle. Many attempts have been made to solve the problem on the basis of application of hydrodynamic principles, but if a successful procedure is devised it will no doubt be kept closely secret until the end of the present conflict.

Recommendations

This brief resume of the general principles of aviation physiology and the more pressing problems now awaiting solution by the air corps of the belligerent nations makes it obvious that no time should be lost, or expense spared, in establishing laboratories of aeronautical research. From the point of view of the United States' program of Medical Defense, it is well to realize that for the last five years Germany has had 20 government-supported research laboratories of aeronautics and this has no doubt been responsible for her notable achievements in recent air warfare. At the present time, the United States Government is supporting one full-time aeronautics research laboratory with subsidiary stations established at several of the training centers and two small recently developed units established by the Bureau of Aeronautics of the United States Navy. If we are to maintain parity in the air with the belligerent nations, it is vital that as much attention and support be given to the physiological aspects of aeronautics research as to the physics of design, armament, etc. It is astonishing that in the present national emergency there have so far been no allocations for research in aviation physiology from the enormous sums set aside for national defense for aeronautic research.

Unfortunately the same is true, up to the present time,* for Medical Defense as a whole in the United States. It is an old teaching, first made clear to the world by Napoleon, but evident to belligerent governments many centuries earlier, that in time of war disease destroys many more "fencible men" than do armaments. No government can be said to be really prepared for war unless its medical defenses are prepared. To place Medical Defense in a secondary role is at once to ignore the lessons of history and to court disaster.

REFERENCES

1. Armstrong, H.G. Principles and practice of aviation medicine. Baltimore, Williams & Wilkins, 1939, xii, 496 pp.

2. Boyle, R. The spring and weight of the air. London, H. Hall, 1660.

AVIATION MEDICINE

The editor of the New Orleans Medical and Surgical Journal (Aug. 1940) reminds physicians of the opportunities that aviation medicine offers both in civil and military life. As a result of World War I it has been definitely shown that the careful selection of pilots on a physical basis was absolutely essential. Statistics showed that of every 100 pilots killed, two died as a result of enemy action, eight from defective equipment, and 90 from defects in the pilot themselves. As many as 50 per cent of the students in training developed neuroses before graduating as pilots. As a result of this experience a postgraduate school of training for flight surgeons was made a part of the Army medical education system.

There are over 31,000 licensed airplane pilots and 15,000 more in the training process in this country today, according to Armstrong. These must all be kept in physical and mental health. There are many special problems concerned with this task and the medical profession must acquaint itself with them.

The Army Medical Department is providing courses in aviation medicine for its medical officers. George Washington University School of Medicine presented a postgraduate course in aviation opthalmology and aviation medicine this year, and two undergraduate schools have begun lectures on the subject to juniors and seniors. Armstrong predicts that other medical schools will undoubtedly follow this lead.

—☆☆—

BIRTH CONTROL POLL

During August the Connecticut Committee To Make Birth Control Legal issued a statement that a personal poll completed by volunteer interviewers showed 93% of the citizens of this State favored giving doctors the legal right to furnish birth control information. Under the direction of a board of directors of 22 members and an executive committee of 14 members the committee is now engaged in organizing local groups throughout the State to conduct a widespread education program, looking toward a revision of the present law.

---

*September 19, 1940. On September 20 it was announced that the President had appointed a Health and Medical Committee to coordinate the medical preparedness program with the Council of National Defense. It was implied that national defense funds would become available to the new committee.

Aviation Medicine Today

WILLIAM B. SMITH, M.D.,*
Hartford, Conn.

I well remember my first flight in 1924, which was made in one of the old Jennys, or more properly the JN4 class of the Army Air Corps. We flew through the air at the amazing speed of ninety miles an hour and prided ourselves on flying about as fast as man could expect to go. Today, we have built a bomber capable of flying five hundred miles an hour. It is obvious that the developments in structure and power plant in the intervening years must have been amazing. The results, of course, tell the story.

In the space alloted for these few thoughts, it is not possible to enter into detail concerning the various developments, but the most important thought for the medical profession to ponder is the human machine which is necessary to handle the mechanical machine which has evolved from these years of flying. I am sure that Mother Nature has not kept apace with the mechanical development. The human machine is little, if any, improved over that which handled the old airplane of twenty years ago. In fact, I sometimes believe that our human machine is not as good as the one that handled the airplane of that period. Therefore, the medical profession has been called upon to handle a very complex and serious problem, namely, to select and supervise personnel to handle the modern military flying machine.

During the last World War, the British, followed by our own Air Corps, developed a yard stick by which to pick and supervise flying personnel. That yard stick was a combination of the various specialties in medicine and which constituted a system known as aviation medicine. I would venture the opinion that since that time there has been very little which we can call new development in aviation medicine. Research in this field has been largely in the subjects of physiology and psychiatry, more particularly physiology. After all, the effect of altitude, speed and fatigue on the human system is a matter of physiology. Through the medium of the airplane, much research has been done on oxygen pressure at the higher altitudes and its effect on the human. It might be interesting to note at this point that the ceiling for aircraft now in existence is about thirty-seven thousand feet. At this altitude, speed, rapid descent or even rapid ascent, present problems to the human which are of the utmost importance and are a challenge to the medical profession.

I would like to emphasize that there are two fields of flying and that each presents its particular problems. These two fields are military and civil. The military flight surgeon and those groups researching in military aviation medicine are confronted with a very much different problem than that found in civil flying. Whereas in civil flying speeds are at all times under deliberate control, rates of climb are moderate, descents are made with care; in the military field, the pilot may be called upon to do a great amount of maneuvering under emergency conditions. His rates of ascent and descent may of necessity be very rapid. Furthermore, he finds it necessary to do a complete line of aerobatics, including rolls, loops, immelmans, et cetera, all of which, it should be obvious to the medical man, exacts strain and stress on physical structures that could cause imminent death or which at least so interfere with the normal performance of the human that his flying becomes immediately erratic and unsafe. It is obvious that these are studies in the field of physiology.

In addition to performance, there have been other developments in military aeronautics as the result of research, such as the improvement in clothing, lenses, apparatus for the use of radio and protection of the pilot from the elements by the means of sliding cockpit covers, et cetera. In this field a problem has been presented which is constantly receiving the attention of both the medical men in aeronautical research and the lay collaborators, namely, the arrangement of instruments on the panels of the airplane. In the old Jenny there weren't more than a half dozen instruments, of which about three or four were important, but in our present complex flying machine there are approximately seventy-five instruments, all of which are important. Whereas the old pilot would fly by the "seat of his pants," it requires a man of extreme alertness and a very stable nervous system to handle one of our present military airplanes.

---

*Chief Flight Surgeon, Department of Aeronautics, State of Connecticut

This development has caused a great deal of research to be done in the field of neuropsychiatry, as well as in the field of physiology. I can't help but point out what we hear so often today about the superiority of British bombing over that of the German type, for the British are accredited with doing much more accurate flying and bombing at night. This is thought to be due to the superior training of the English pilot on the instrument board above mentioned. Of course, the instrument board is a complicated mechanical device, but would be of no value whatsoever if the human using it could not adapt himself to the arrangement of the large number of instruments before him.

Therefore, today in military aeronautics we are faced with the question of mechanical developments in airplane structure and power plant resulting in speed versus the human machine, which has not kept apace with these developments. The modern airplane has been constantly re-designed and improved throughout from wing tip to tail surface and from every strut to every bolt, but I must lament that we stick to the same old method of human construction; the brain is suspended the same way that it has been for centuries, the stomach and intestines are in the same location and swing in the same pendulum fashion. Nothing has been done to improve the nervous system and its most intricate ramifications. We see with the same old eye, in fact, an eye probably not as good as it was twenty-five years ago, and, finally, the blood supply to all these structures still presents the same shortcomings as it always has. The whole matter can be very much compared to the simile of the Model T Ford being asked to keep up with our present streamlined automobile and its high compression engine. The Model T might find the load rather heavy.

There must come a time, therefore, when we shall find that the mechanical development in military aviation, as well as civil aviation, will be influenced and limited by the physical-mental shortcomings of the human being. In fact, I am of the opinion that that time is now at hand.

☆☆

WHY PUBLIC RELATIONS?

The physician who asks what tangible results medicine's Public Relations Program has returned to him is best answered by examining his present status in American life.

He is not yet regimented.

Politics have not gained control of his profession.

He still enjoys free competition, and the fee system of private practice.

His average yearly income is still a professional income.

The American way of life — which has fostered democratic progress in science — is still with him.

Despite the threat of organized pressure groups, organized medicine has survived the Turgid Thirties with few casualties.

Those physicians who are doubtful of the value of their national, state and county public relations programs should ask themselves what is the worth of these things having been preserved for them; should examine their conscience to determine what would now be their way of life if these values had been lost.

Westchester Med. Bull., Aug. 1940

THOUSANDS HAVE SAID

"Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2)

The Medical Aspects of Deep Sea Diving

C. W. SHILLING, LIEUTENANT COMMANDER,
MEDICAL CORPS, U. S. NAVY.

Classical historians record for us many stories of the employment of "naked" divers, even as early as 460 B.C. In the intervening centuries men have continued to dive to great depths without any type of suit and even today in many parts of the world similar practices are employed by those engaged as pearl and sponge divers. They have been able to dive to depths as great as 200 feet and to stay under the water for as long as 4 minutes 46¼seconds. However, according to Davis[1], the average time is not more than 1½ minutes and the usual depth not more than 80 to 100 feet for most "naked" divers. Other than the obvious dangers from fish and giant clams the naked divers are exposed to the possibility of lung collapse when attempting great depths.

The diving dresses pictured in early histories appear amusing and more like Rube Goldberg inventions than any serious attempt to make under water work easier. It was not until 1857 that Siebe of England made a practical diving dress which has served as the model from which the modern diving dress has been developed. With this new diving dress came deeper work for greatly extended periods of time and unfortunately, also, new physical hazzards were encountered.

The most important of these is Compressed-Air Illness which has been variously called Caisson Disease, Bends, Aeropathy or Diver's Paralysis. The literature concerning this condition is extensive[2], but for the purpose of this paper only a brief description will be presented. The condition was first accurately described in 1845 although symptoms were noted as early as 1820. There were many and varied hypotheses presented as to the cause but none of them have stood the test of time except the gaseous emboli theory. This theory is based on the fact that as the individual breathes compressed air, whether it be in a diving suit, bell, caisson, or tunnel, the blood circulating through the lungs is exposed to a partial pressure of nitrogen and oxygen proportional to the air pressure, and takes up an extra amount of nitrogen and oxygen proportional to this increased pressure. As the blood circulates through the body the extra oxygen is used by the tissues but the extra nitrogen is not used, and gradually saturates all of the tissues until they are charged with nitrogen at the partial pressure existing in the air breathed. It is evident at once that there are two factors involved in this saturation, namely, the depth or degree of pressure and the length of time exposed to this pressure.

If the air pressure is lowerd slowly (decompression) then the process is reversed and the nitrogen is given off through the lungs and equilibrium again established with atmospheric air pressure. But if decompression is too rapid, the blood and tissues, which are supersaturated with nitrogen, are left with an internal partial pressure far above the external atmospheric partial pressure. Under these conditions the nitrogen tends to leave the blood and tissues in bubble form and produce local or general blockage of the circulation or they may produce painful pressure or tearing of the tissues. The symptoms of the illness vary according to the location of these bubbles and the local tissue damage produced.

Thus we have three principal factors involved in the production of compressed-air illness: degree of air pressure to which exposed, length of time exposed to this pressure, and the length of time taken to come out from this pressure to atmospheric pressure. In addition to these we have certain physical predispositions having a secondary bearing on the production of the illness which are: age, systemic disease, degree of fatness, alcoholic consumption and fatigue or general malaise.

Since the pressure of free gas in the blood or tissue fluids is the cause of the illness, it is evident that the variety and severity of the symptoms will depend upon: the location of the gas set free and, the volume of this free gas. Thus, unconsciousness, collapse, and early death may result from emboli in the pulmonary or coronary arteries, or in the vessels supplying the vital centers of the brain. Pain may result from bubble formation in any unyielding tissue such as ligaments, fascia, periosteum, muscle spindles, or nerve sheaths. Air embolism either of the vessels or white matter of the spinal cord may cause paraplegia; while involvement of the cerebral vessels or tissues may lead to monoplegia, hemiplegia, aphasia, or sensory paralytic symptoms. Symptoms rarely develop from bubbles in the liver, spleen, kidneys, adipose tissue or veins. These "silent" areas far outnumber the "painful" areas, which in turn outnumber the "vital" areas; so except in cases of massive bubbling, the chances of serious involvement are slight.

The treatment for this condition may be summarized by saying that the patient must be immediately placed under increased air pressure and that this pressure should be carried to at least the pressure of the original exposure, that this pressure should be maintained until symptoms disappear or for a minimum of 30 minutes or a maximum of 2 hours and that the return to atmospheric pressure (treatment decompression) should be much slower than the original return to atmospheric pressure. Oxygen or helium-oxygen mixture should be breathed during this decompression and massage, exercise and nursing care given as indicated.

Since, as pointed out earlier, the cause is the failure to properly eliminate the excess nitrogen, it then follows that prophylaxis depends upon the proper return to atmospheric pressure which process we call decompression. The exact computation of the length of decompression necessary depends upon the length of time exposed and the depth of the exposure, and is based upon physiological factors of saturation and desaturation times of various tissues. Tables have been prepared and prescribed for the divers in the U.S. Navy and for compressed air workers in various States.

One of the greatest difficulties experienced by those going under pressure is difficulty in clearing the ears or in equalizing the pressure through the Eustachian tubes so that it will be the same on both sides of the drum. Thus it is immediately seen that acute upper respiratory infections at once eliminate men from taking pressure. Much has been written concerning the damage to ears when trying to take pressure and the author frequently sees ear drums that have been severly damaged, even ruptured, by ill advised attempts to force the ears in trying to take pressure.

Perhaps the most interesting effect of high pressure air is that upon the mental and neuromuscular responses of those exposed. They have a definite feeling of stimulation which they liken to a feeling of "drunkenness". In spite of exaggerated confidence in their ability accomplishment falls far short of that demonstrated at atmospheric pressure. This was noted by Phillips[3] who found it associated with emotional disturbances, and ascribed the condition to psychological changes. Others reported such changes and attributed them to "the narcotic effect of the increased nitrogen tension." Practically it has been demonstrated many times that there is an appreciable decrease in mental ability, characterized by increased difficulty in the assimilation of facts and in the making of quick and accurate decisions. This mental sluggishness may be ascribed to the slowing process of cerebration.

Also there is a lengthening of the reaction time and a loss in neuromuscular control and response. Data were presented by Shilling and Willgrube[4] which actually measured these changes and proved quantitively the accuracy of the experiential deductions. The real importance of this condition is seen when it is realized that the limiting factor on the depth to which a man can go is found in this field and in no other. This was illustrated during the Rescue and Salvage operations on the U.S.S. Squalus where much difficulty was experienced with the divers; one master diver with wide experience began calling football signals from the deck of the sunken submarine and he had to be brought to the surface at once; another diver lost consciousness completely and had to be brought up the descending line by his diving partner; still another man was trying to cut his own life line and air hose when he was taken in hand. The limiting depth for most divers breathing air is about 300 to 320 feet for any practical work. Certain other physiological changes occur such as slowing of the pulse rate, lowering of the systolic blood pressure and lessening of the pulse pressure, lessening of the blood circulation time, changes in the blood chemistry, and loss of cardiac efficiency but they do not assume the importance of the mental and neuromuscular changes although they may be contributing factors.

The most spectacular recent development in deep sea diving is the adoption of a mixture of helium and oxygen as a substitute gas for air in very deep dives. Although helium was suggested as early as 1919 the first practical work for diving was done during the salvage of the Squalus. In this connection Behnke and Willmon[5] say: "In contrast with previous diving methods, the distinguishing features of the diving technic were the successful employment of helium-oxygen mixtures for deep diving in cold water, made necessary by the failure of the standard method of using air . . ."

The interval between the first suggestion in 1919 and the successful use of helium-oxygen in diving on the Squalus in 1939 was not bridged in one stride for during this time experimental work was done which established the following facts: that helium was colorless, odorless, tasteless, physiologically and chemically inert; that it can be liquified and solidified and has a density one-seventh that of nitrogen and one-eighth that of oxygen; that its solubility in water and serum under standard conditions is a little over one half that of nitrogen and that its solubility under pressure is directly proportional to the pressure of the gas according to Henry's law; that it has much greater diffusibility than other gases and therefore less effort is required to move it through semi-permeable membranes and narrow orifices; that mixtures of helium and oxygen could be breathed by men and animals at atmospheric pressure for extended periods without harm and that breathed under increased pressures it caused no untoward physiological changes.

These properties led to its trial in medical conditions where a mixture of 80% Helium—20% Oxygen proved of value in the treatment of such conditions as asthma, emphysema, obstructive lesions of the trachea, larynx and bronchi, pneumonia and cardiac decompensation. It has also been used as a diluent and vehicle in the giving of gas anesthesia.

The rationale for the use of helium-oxygen mixtures in diving is that helium has the advantage of being less soluble than nitrogen and also that it diffuses more rapidly in the body fluids and tissues which results in more rapid elimination of the gas from the body during decompression. Thus decompression time can safely be shortened without danger of developing the "Bends." The mixture could also be breathed following a dive thus facilitating the elimination of nitrogen and shortening materially the time necessary for decompression.

However, the most important consideration in the use of helium-oxygen mixtures for diving is that, as reported by End[6], it lessens and in some cases eliminates the untoward mental and neuromuscular symptoms observed under increased air pressure. As noted earlier this change was demonstrated during the salvage of the U.S.S. Squalus.

Although much has been accomplished in the study of the medical aspects of deep sea diving there are still many problems unsolved which remain as a challenge to those who are interested and working in this field.

BIBLIOGRAPHY

1. Davis, Sir Robert H. Deep Diving and Underwater rescue. J. Roy. Soc. Arts, 82: 1032-1080; 1934.

2. Shilling, C.W. Compressed-Air Illness. U.S. Navy Med. Bull., 36:7-17, 235-259; 1938.

3. Phillips, A. E. Recent Research Work in Deep-Sea Diving. Proc. Roy. Soc. Med., 25:693-703; 1932.

4. Shilling, C.W. and Willbrube, W.W. Quantitative Study of Mental and Neuro-Muscular Reactions As Influenced by Increased Air Pressure. U.S. Navy Med. Bull., 35:373-380; 1937

5. Behnke, A. R. and Willmon, T. L. U. S. S. Squalus. Medical aspects of the rescue and salvage operations and the use of oxygen in deep-sea diving. U.S. Navy Med. Bull., 37:629-640; 1939.

6. End, Edgar. Rapid Decompression Following Inhalation of Helium-Oxygen Mixture Under Pressure. Am. J. Physiol. 120; 712-718; 1937.

The Increasing Importance of Preventive Industrial Medicine

ALBERT S. GRAY, M.D.,*
Hartford, Conn.

The physical welfare of industrial workers has been receiving an increasing amount of attention in the United States during recent years. Indisputable evidence is available to prove that industry and labor have made tremendous progress in the improvement of industrial health conditions and today the average worker is located in a more healthful environment than ever before. This forward move was not stimulated by an alarming outbreak of occupational disease nor was it due to any marked increase in industrial health hazards, but is the logical result of the co-operative efforts of the medical profession, public health agencies, and others, to more effectively combat preventable and unnecessary illness.

It is gratifying to all people interested in improving the public health, and particularly to those concerned with preventive medicine, to note that the industrial worker is being looked upon more and more as a physical being capable of paying rich dividends in service when healthy or as an economic and social liability when physically unable to earn a living. Industry is becoming increasingly convinced that good business and good health are so inseparably related that one cannot be fully realized without the other. During the earlier periods of the present era of the mechanization of industrial operations many industrialists reckoned with their problems of mass production and the resulting profits or losses quite largely in terms of the efficiency of mechanical equipment. Consequently, rapid progress was made in the perfection of machinery which would speed up operations, reduce production costs (often times at the expense of employees) and turn out improved products. Throughout many of these efforts to develop super factories the physical efficiency of the working man was taken more or less for granted or was not given an adequate amount of attention. The result of this neglect of the employee's health frequently was detrimental to the entire scheme of developing highly mechanized industries. It soon became evident that the machine usually was no more proficient mechanically than was its operator physically. These lessons together with legislative enactment and co-operative efforts of the various agencies involved were responsible for the inauguration of a new era insofar as the physical welfare of industrial workers was concerned.

The earliest type of industrial medical service was limited almost exclusively to the surgical repair of accident victims. This type of service was considered adequate for a time because injuries constituted the major industrial health hazard. However, it soon became obvious that the prevention of industrial accidents was more profitable than just patching up the injured so the attentions of the safety engineer, industrial surgeon and others were directed along the lines of correcting the circumstances responsible for accidents. It was here that the foundation of the modern system of preventive industrial medicine was laid. From this beginning the various services designed for safe-guarding the employee's health have continued to grow until at the present time industry and labor definitely recognize that the conservation of industrial health is of vital economic, humanitarian and social importance. So, too, the medical profession and public health officials realize that the prevention of industrial diseases and accidents provides a splendid opportunity through which efforts to improve the general health of the working population may be accomplished.

It would seem, in view of the many examples of the value of industrial health protection, that there would be little need for a discussion at this time dealing with the importance of the work. However, it is quite obvious that, as yet, modern industrial health conservation is still in the earliest period of its development and that further progress is of vital importance to industry, labor and the public. Many industries are not taking adequate steps to protect the health of workers while others are taking no voluntary steps whatsoever along this line. Hordes of employees do not fully appreciate their own responsibilities along these lines or never have heard anything about what they can and should do to protect their health. Many physicians have but little knowledge or appreciation of the practice of preventive industrial medicine, and many public health officials do not fully appreciate that control of industial health hazards affords an unequaled opportunity to raise the general health level of this important part of our population by bringing to them other public health facilities.

---

*Director, Bureau of Occupational Diseases, Connecticut Department of Health.

The available morbidity and mortality statistics, incomplete as they undoubtedly are, clearly show that much remains to be done to bring the health status of industrial workers up to a plane favorable to that of the population as a whole. Notwithstanding the fact that general health conditions in industry are at a higher level than ever before, this level is not satisfactory. It is obvious that if continued improvement in industrial health is to be achieved, many industries must improve their medical facilities and labor must accept its responsibilities in the program. More physicians must become familiar with preventive industrial medicine and the wide opportunities for service it provides — and public health authorities must utilize to a much fuller extent the opportunity which control of industrial disease provides to improve the general health of the working population.

This does not mean that progress is not being made. As has been mentioned elsewhere in this discussion, the interest in occupational disease control has increased tremendously, particularly during the last few years, and the outlook for the future is most encouraging. An increasing number of plant officials are providing adequate services; employees are showing an encouraging amount of interest in the problem; the number of official industrial hygiene bureaus in the United States has increased from four prior to 1934 to more than thirty at the present time, and more and more physicians are becoming increasingly cognizant of the influence which employment may exert upon the health of the patient. All of these forces are working together more completely than ever before and it may be confidently predicated that in the near future industrial medicine will be regarded as one of the most important branches of preventive medicine.

The industrial situation in Connecticut presents some problems which are somewhat unique and without parallel elsewhere. The highly specialized type of manufacturing for which the state has been noted for such a long time; the types of activity and the characteristics of the employees operate collectively to intensify the potential and actual industrial health hazards. Of the gainfully employed people in the state, almost fifty per cent are engaged in the types of plants which usually have the more important industrial health hazards. The social and professional scales of employees range from the most ignorant and unskilled laborers to the most highly trained technical workers to be found in any type of industry. The heterogenicity of these people further add to the complexities of controlling occupational health hazards.

The recent expansion of industrial activities incident to the National Preparedness Program has further increased the complex problems ininvolved in the control of health hazards. Connecticut is forty-sixth among the states in area and twenty-sixth in population, yet it is one of the four leading ones in importance in the National Preparedness Program. As a result of the tremendous role which the state is playing, at the present time, industrial health supervision problems have been considerably intensified.

In order that industries can comply with the increased demands created by the Preparedness Program it is necessary that they expand activities beyond levels experienced during normal periods of industrial activity. Production schedules are stepped up; new processes of unknown health significance are inaugurated; old hazardous operations are reinaugurated in some instances; hordes of workers are employed, including many who are unfit for the job because of physical defects and inadequate training. The results of these abnormal circumstances will increase industrial health and accident hazards, consequently, it is important that greater effort be exerted to control these conditions.

It is appropriate, at this time, to commend the medical profession of Connecticut for the progressive and beneficial services which have been rendered in the field of industrial medicine. The many physicians who engage in industrial practice either on full time, part time or fee basis, are rendering as high type of service as can be found anywhere. However, the continued improvement in the quality of industrial medicine demands that many problems be solved and that greater effort be expended to extend this type of service.

It is not possible or necessary that every physician be a specialist in industrial medicine or that he spend a great deal of time studying the many possible ways that occupation may affect the health of his patients. But it is important that the possible magnitude of industrial hygiene problems be appreciated and that the physician be willing to cooperate with others who are more directly concerned with efforts to prevent unnecessary health hazards in plants.

It is particularly desirable that physicians improve their cooperation in reporting occupational diseases. The Bureau of Occupational Diseases of the Connecticut State Department of Health uses the reports in studying the incidence of industrial diseases and for guidance in carrying out control measures. Of all the cases of occupational diseases which have been brought to the attention of the bureau during recent years, less than fifty per cent of them are reported by physicians. A large majority of the other cases were reported by the various compensation courts of the state.

It is not within the scope of this discussion to discuss all of the problems which confront physicians concerning occupational health hazards. It would seem sufficient to point out that in the changing concept of industrial medical service it is important that physicians be aware of the fact that they will occupy a very important role. They will be expected to render scientific service to many cases of industrial diseases and serve as a source of information and guidance to the workers and industry concerning the effects of exposures of various types upon health. The degree to which this fact is accepted and the extent to which physicians prepare themselves to deal with the situations which arise will have a profound influence upon the progress of this phase of preventive medicine. It is particularly important that the abnormal health conditions which are likely to result from the present abnormal industrial activities be taken into consideration and that more effective plans for dealing with then be formulated.

Summary

The present trends in the studies and control of industrial health hazards have resulted primarily from a logical development of the theories and practices of preventive medicine. The welfare of industrial workers will continue to receive an increasing amount of attention and all agencies concerned with the prevention of illness will be involved. The beneficial role of private physicians in these preventive efforts cannot be denied and it is predicated that the demands for their services will increase more rapidly in the future than has been the case during the past few years.

The industrial situation in Connecticut normally is unique and without parallel due to the highly skilled types of operations carried out and to the marked heterogenicity of the workers. Due to these peculiarities the industrial hygiene problems are more important than usually are found in industrial areas. The added potential hazards which will occur along with the abnormal expansion of industrial work incident to the National Preparedness Program, will further intensify the importance of more effective control efforts.

It is appropriate that every private physician become more aware of the normal industrial health problems in the state and of the increasing opportunities for rendering effective service in this phase of preventive medicine. He also should appreciate the potential health importance which the present abnormal industrial situation is creating and redouble his efforts to cooperate in efforts to control any unhealthful conditions which arise.

Blast Injuries to the Lungs

By blast is meant the compression and suction wave set up by the detonation of high explosive (H.E.) As a result of World War I three theories were evolved as to the cause of pulmonary lesions produced by explosion, but there are no records in available published papers or confidential reports of any experiments designed to show how these pulmonary lesions are caused. The three theories are as follows:

1. The lesions are due to a lowering of the alveolar pressure by the suction wave (which follows the high pressure wave), acting through the respiratory passages, with consequent rupture of the alveolar capillaries.
2. The lesions are caused by the distention of the lungs with air.
3. The lung lesions are due to the impact of the pressure wave on the chest wall.

In the British *Lancet* (August 24, 1940) appear both a report of a series of experiments on blast injuries to the lungs as well as a report of a series of actual injuries to human lungs from H.E. blasts. The experiments reported by S. Zuckerman suggest that the third theory as stated above is the correct one and that injury to the lungs is caused mainly by the impact of blast wave on body wall. Mice, rats, guinea pigs, rabbits, cats, monkeys and pigeons were exposed in the open to blast from the explosion of charges of H. E. and from explosion of hydrogen and oxygen in balloons. In the H. E. experiments no animals were ever killed at distances further than 18 feet and none was ever hurt in any observed way at a distance further than 50 feet from the explosion. Almost all animals were killed between 13 feet and 18 feet, distances where the positive components of the blast wave (hydrostatic pressure) varied between 126 and 62 pounds per square inch. In no animal was there any external sign of injury, and the outstanding lesion was bilateral traumatic hemorrhage in both lungs, varying in degree according to the distance of the animals from the charge and the pressure to which the animals were subjected. In all cases where the degree of lung injury was sufficient to kill the animal, blood was present in the upper respiratory passages; it was also present in a few cases where animals recovered. The lesions were detected radiologically. The pulmonary lesions caused by blast from balloon explosions were the same in character and were bilateral except when animals were placed so close to the balloon that the exposed side shielded the other. In the latter case the lesions were mainly or entirely unilateral and confined to the exposed side. Animals whose bodies were clothed in thick layers of rubber suffered little or no damage compared to the controls. From these experiments the author draws the conclusion that it is the pressure component of blast which bruises the lungs by its impact on the body wall.

Dean, Thomas and Allison, reporting from a Royal Navy Auxiliary Hospital, present a series of 27 cases of men wounded by close-up shell or bomb explosion, dying without any apparent wound. All 27 had been close to bursting high-explosive bombs and they were examined 7 to 10 days after the event. There were 21 with extensive superficial burns. Of the rest, 5 had fractures and 1 had multiple splinter wounds of the legs; 7 had been concussed by the explosion, 3 immersed in the sea, and in all but 2 there had been direct exposure to heavy blast at relatively close quarters. These authors know of no cases of this kind yet reported during the present war. In this series only 6 complained of symptoms related to the chest; 16 showed some abnormal physical signs and 14 showed abnormal radiological appearances. Evidence of serious or gross pathological changes in the chest was absent in all but 2 cases; 1 of these had signs of collapse of a lobe of the lung, the other had signs of a patchy consolidation of the bronchopneumonic type. These cases showed a relative disproportion in frequency between the symptoms (cough, expectoration, shortness of breath and restlessness) and the physical signs. The physical signs to be expected are (1) diminished movement of the diaphragm, (2) fulness of the chest giving it an emphysematous appearance, (3) impairment of resonance at one or both bases, with or without crepitations. Frequently there is a "blown up" or ballooned appearance of the chest, especially at the lower costal margins, after such injuries. The radiological appearances of a diminution of rub expansion, together with a slight loss of translucency, particularly on the left side, are striking. This appearance theoretically should be produced by a pleura slightly thickened by bruising and "bruised pleura" may be the pathological condition present.

All this goes to show that the lungs can be damaged by blast without there being any injury to the body surface. The editor of the *Lancet* reminds us that in view of the delay before symptoms develop and the indefinite physical signs there is danger that the condition will go unrecognized and that the accompanying shock will be put down to other causes. In cases of asphyxia due to this cause the Schaefer method of artificial respiration will prove not only ineffective but even harmful, and this will have to be made clear to first aid workers. The results of this experimental work and the knowledge obtained from the 27 cases reported by these British Naval Officers present further arguments why the civilian population should take shelter during an air raid. When no cover is available the effects of high explosive on the lungs can be greatly lessened by adopting the approved prone position on the ground, preferably behind some substantial structure.

☆☆

DATE SET FOR 1941 A. M. A. SESSION

The Board of Trustees of the American Medical Association has selected June 2-6, 1941, as the date for the Ninety-Second Annual Session of the Association to be held at Cleveland,

PREDICTS WARTIME SCARCITY IN PHYSICAL THERAPY FIELD

In case of war there would be a shortage of at least 250 physicians qualified to take charge of physical therapy departments in the number of general hospitals it is estimated would be required for six field armies, and an even greater shortage of technicians in this field would exist, John S. Coulter, M.D., Chicago, declares in the Medical Preparedness Section of *The Journal of the American Medical Association* for Sept. 7.

Dr. Coulter estimates that 300 general hospitals of 1,000 beds each would be necessary "in a war of such severity as is occurring in Europe" and that in each such hospital a medical director and at least six technicians would be required for the physical therapy department. At present the number of qualified physicians specializing in this field appears to be less than fifty, as the Society of Physical Therapy Physicians has a membership of only thirty-eight and a waiting list of ten.

Discussing ways of overcoming the shortage in this field, Dr. Coulter says: "The Northwestern University Medical School for the last ten years has been offering to qualified graduate physicians a month's course in physical therapy. It is felt that this course serves as a substantial foundation for the intelligent application of physical therapy. A physician with a year's internship and at least a year's approved residency can in this month's course secure a groundwork in physical therapy that will enable him in the event of an emergency to take charge of the physical therapy department of an army general hospital. It would seem desirable that some provision be made to train medical officers in such short courses as the need arises. At least ten medical schools and the Mayo Clinic have facilities to give such courses as described."

Regarding physical therapy technicians, Dr. Coulter points out that a course of forty hours a week for twenty weeks could be given without lowering the educational standards.

BLOOD PRESSURE? PRESTO!

You are always asking, "What's new?" The Taylor Instrument Co. answer with their introduction of a manometer cuff based on an entirely new time saving principle. Fits instantly all sizes of arms without twisting or slipping. For sale by The Professional Equipment Company. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

(SEE PAGE 2)

MESSAGE FROM THE PRESIDENT

Connecticut State Medical Society

MEDICAL PREPAREDNESS COOPERATION

The United States Government has accepted the facilities of The American Medical Association in the task of building up the Medical Department of the military defenses of the country. Wisely, the Administration in Washington has foreseen the advantages of joint action in this undertaking.

Experience in previous emergencies reveals incongruities in medical posts which impaired the efficiency of the service. Proper selection and assignment of physicians on the basis of physical and professional qualifications is essential in expanding the Medical Department. Of equal importance — at this time — is the matter of maintaining community health and safeguarding the health of workers in industry.

The American Medical Association with, and through, its component State Medical Societies and County Associations is best able to pass upon the qualifications of its members and will be most useful in making recommendations for their assignment. Each State Medical Society may follow a uniform plan of action laid down by the parent organization in conjunction with the Federal Government. There is no question but that with such cooperation the best use of the doctors will be made and only the minimum disruption of the civilian practice will occur.

Requests for necessary information relative to individual members need cause no apprehension. Questionnaires on qualifications and availability for service should be gladly and promptly answered. Cooperation, as always, will help to bring about the best results.

The American Medical Association has taken on great responsibilities in connection with medical preparedness. The Connecticut State Medical Society stands ready and eager to do its part.

ARTHUR B. LANDRY, M.D.

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief*,	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Stamford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — William M. Joyce, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

MEDICAL PREPAREDNESS

Whether or not these United States become engaged in active combat as World War II spreads from one continent to another, the need for preparedness at last has been recognized. Medical preparedness is but one phase of the vast program but the one which concerns each physician today. Congress has already passed and the President has signed a bill calling for military training of every man without dependents and physically qualified between the ages of 21 and 35. Physicians will not be exempt from this training. As the editor of the New York State Journal of Medicine has so aptly stated, "merely to put physicians in uniform does not make military surgeons."

Each armed unit of 1,000,000 men calls for 7500 physicians. In the event of war probably a minimum of 4,000,000 men would be mobilized and for this force 30,000 physicians would be required. Today in the medical reserve corps of both Army and Navy about 15,000 physicians, or one-half the required number, are available. It will be evident to anyone who has followed the accounts of the type of warfare now being waged that the problems of military medicine and surgery today are quite different from those even of World War I. Postgraduate military training will be necessary to prepare physicians for service with the armed forces. Even our youngest practising physicians, except those already serving with the National Guard or Medical Reserve Corps, are ignorant of the problems facing them in military service. It is upon these younger men that the burden of medical military service must fall and at present the need for them is great as shown by the dearth of lieutenants and captains in the U.S. Army Medical Reserve.

The other great problem of military preparedness, that of the examining boards, concerns more the older physicians as it is most likely that from this group over 35 years of age will be selected these boards. Connecticut and the State Medical Society occupy an enviable position in the plans for handling the medical phases of the Selective Service Law. As outlined elsewhere in this issue of the *Journal*, the organization for this purpose will be exactly as anticipated by the Preparedness Committee of the State Medical Society. This organization has been under development here for some weeks. Due to the vision and efforts of our own Executive Secretary our Society has been asked to suggest the names of physicians to serve as examiners on local Selective Service Boards and on Medical Advisory Boards. Those thus selected will be recommended for appointment by Governor Baldwin. In only a few other States does the medical society occupy such an enviable position.

Organized medicine has been loud and repeated in its request for an official body to coordinate medical and health measures. Such an objective has been attained in a Committee on Medicine and Health of the National Defense Council under the chairmanship of Doctor Irvin Abel, immediate past president of the American Medical Association. This accomplishment is most gratifying and should be a source of great satisfaction to every physician.

It is obvious that every one must share in the preparedness program, physician, lawyer, mechanic, farmer. Just how the physician may be relegated to tasks for which he is not trained or afforded no opportunity for proper training for newly assigned duties, was well exemplified in our last World War. The preparedness program is developing today along more carefully planned lines and should produce results comparable in efficiency. The opportunity is ours as a Society and as individuals in collaborating in this medical preparedness program.

—☆☆—

FROM PEACE TO WAR

In civil life during peace the relation of the physician or surgeon with the patient is an implied contractural one in which the former provides a service desired by the latter and for which he is directly compensated. While the common good is constantly in the physician's mind, he assumes that this is best achieved by providing the best of service for the individual, save in those rare instances where there is a direct conflict with this and the public interest.

The situation changes at once with the onset of war; the common good has for its dominant and major objective the winning of the war to which in such times all energy must be turned, whether it be involved in the armed forces or in civilian life. While in the latter, the interference with the individual relationship of the physician and the patient may be kept at a minimum, it is certain that such cannot be the case when both patient and physician are members of the armed forces. The specific objective with which they are charged is the winning of the battle by direct and common action, and, in doing so, individuality must be sacrificed for the common good. This change in attitude for the physician passing from practice into the army or navy, is frequently a more difficult matter than is the adaptation of his professional skill to the new situations.

Sickness and casualties must be thought of in terms of the loss of effective strength whether this be by direct depletion or indirectly by the impeding of movement of personnel and material or by impairment of morale. To prevent disease is an important thing, but only by measures which do this with the minimum of interference with the primary function of the army, that is the winning of the war. It would be possible to devote so much energy to safeguarding the forces against illness that their effective strength in combat would be disastrously lowered. In other words, while attempting to achieve a goal within an immediate field of interest, the ultimate objective might be lost. Likewise, in the care of the wounded, the deflection (from other activities) of sufficient personnel and materials to achieve an ideal handling of them, may endanger the achievement of the main objectives. Under these circumstances to give the best care to the largest number of wounded, with the least interference with the combat, and to preserve the effective strength of the forces are the essential functions of the surgeon.

This by no means implies that the physician abandon the high standards toward which he should always strive, but rather that he adjust these to the paramount objectives which necessarily condition his activities. He should not forget that he is a member of a coordinated group fighting for a common end when sacrifice of individuality is the common lot of each member of it. S. C. H.

APPROACH TO EARLY DIAGNOSIS OF MALIGNANCY IN GENITO-URINARY TRACTS

The early diagnosis of a malignancy widens the scope for treatment, which, if carried out, offers the highest possible number of satisfactory results. The fact that only sixteen to twenty per cent of malignancies of the genitourinary tracts show five-year controls indicates that a new approach to the problem is necessary. All malignancies are controllable in their early phases, no matter what organ is involved. The question arises: what are the approaches to early diagnosis? Are they practical approaches? Can they be utilized? Are they difficult or are they easy to discern?

The main approaches are two in number. They are practicable and are easily within the latitude of human application but present themselves as a community problem for the lay person and the doctor. First, the patient should be made "malignancy conscious." To be sure, this is not always possible in the younger individual; but a greater part of the malignancies occur after the fortieth year, hence there is plenty of time for the education of the patient. Malignancies of the bladder are practically all ushered in by hematuria. The importance of abnormal urinations and especially of the presence of blood in the urine should be common lay knowledge. The latter means cancer development to the patient and to the doctor alike until investigative measures have proven otherwise. Cancer of the prostate often begins, and even develops into an uncontrollable lesion, without symptoms, but the male should be made to realize these facts and subject himself to annual rectal examinations after the age of 50 years. Many men are now doing this very thing. The dissemination of these facts could be part of a public health program. The patient can, has been, and often is an obstruction to an early diagnosis by refusing to acknowledge early symptoms or delaying his visit to his physician. There are several reports from our own State that show several months' delay in reaching an early diagnosis due to the patient's failure to follow his own conscience or his doctor's advice.

The second approach to an early diagnosis is wholly through the doctor. It is the doctor's responsibility to do complete physical examinations. Questionable malignancies of the penis are all readily biopsied. Tumors of the testis, which occur usually in the first three decades, are readily exposed under local anaesthesia, can be biopsied if necessary, and, if malignant, immediately removed. Needle biopsy should not be done unless preparations for immediate excision have been made.

Every practitioner should encourage all of his male patients to have a rectal examination every year after the age of 50. We are controlling less than four per cent of all cancers of the prostatic gland today. The reason for this is that they reach the medical profession too late. The only approach to an early diagnosis is thorough cooperation on the part of the patient and the physician for a yearly examination per rectum. If there is a small nodule in the prostate, it can be exposed perineally, biopsied, and completely removed if necessary. The suprapubic approach is not recommended because of the impracticable anatomical approach to the tumor. Needle biopsies are not satisfactory.

Bladder malignancies make their presence known early by frequency of urination and blood in the urine. The early lesion may not show any infiltration of the bladder wall on rectal or vaginal examination. If the bladder has a normal capacity, — that is, if the volume of one urination is 400 to 500 cc., — the lesion must be an early one. If the patient and doctor await small quantity voidings, it may be too late. Cystoscopy makes it possible to locate the tumor and to obtain a specimen for microscopic study, which should always be carried out. Often a small piece of tissue is extruded early, and this should be examined microscopically. Since most tumors of the bladder make their presence known by a few abnormal urinary symptoms of frequency, urgency, and a few red blood cells in the urine, the general practitioner should be very suspicious of all individuals, both male and female, past 40 years of age who show such symptoms.

Kidney tumors develop silently into large tumors in 45 per cent of cases. Others give dull, aching pains in the kidney region or bleed and cause severe ureteral colic. All patients who have hematuria should be investigated cystoscopically, and retrograde pyelograms should be taken. Early lesions might be missed, if only intravenous urography was applied. If there is any doubt about deformity of the pelvis, x-rays should be repeated, especially in children; the same should be true in cases of adults. Many silent tumors are being discovered by routine physical examinations. In such cases, the physicians are to be congratulated, and the lesion should be passed on to all who do less thorough examinations.

We therefore have approaches to facilitate an early diagnosis of cancer for all the organs in the genito-urinary tracts, if we but educate the patient to become conscious of the significance of abnormal urinary symptoms and to seek the advice of a physician. All physicians should be competent to do simple examinations or to see that they are done. The physician should seek to create an atmosphere of cancer confidence within his community. To cure a cancer is equivalent to winning a war and carries with it the joy, the gratitude, and the personal satisfaction of a great achievement which demanded an early strategic approach and a successful attack. The patient and the doctor will be rewarded for their combined efforts.

C. L. D.

☆☆

AMERICAN RED CROSS—HARVARD STUDY UNIT

War brings new problems in medicine no less than in military science. The medical services of the Army and Navy have, of course, a vast amount of information concerning the present highly developed means for human destruction but close observation of events as they take place in Europe is required.

The American Red Cross — Harvard Hospital lately established in England will have in addition to its immediate purpose to help with the medical work, the opportunity to make special studies of health conditions in a country at war and to gather information and experience which can be of value in the development of health measures attending the preparation of a defense program in this country.

The unit under the direction of Doctor John E. Gordon, Professor of Preventive Medicine at Harvard, proposes, among other things, to study epidemics and communicable diseases as they occur in military concentrations. These observations supplemented by laboratory studies will serve as bases for methods to check epidemics when they first appear. An entirely new field will be the study of the effects of aerial bombardment on the civilian population. It is a phase of warfare in which American physicians and psychiatrists have happily had no experience, and it may be that nothing of special significance is to be learned, but if the strain of prolonged bombardments are shown to have important effects, it must be given consideration in a wartime health program.

The relation of Harvard University to the American Red Cross in this enterprise is interesting. From representation in the press it appears to be analagous to the working agreement between medical schools and the boards of directors of teaching hospitals. The Red Cross furnished the plant and nursing service and Harvard University assumes responsibility for the technical staff and the scientific phases of the project.

C. B.

☆☆

DOCTOR BURT PRESIDES

Doctor Clarence E. Burt of New Bedford, Massachusetts was invited to preside over the session of the Clinical Congress on the afternoon of September 18th. Doctor Burt is well known at the Connecticut Clinical Congress. He has attended every session and has so many friends here in Connecticut that he has said that he sometimes feels that he is a member of The Connecticut State Medical Society. Several years ago Doctor Burt was appointed to the Program Committee of the Congress and each winter when the program is to be arranged he comes to New Haven for the conference of that Committee.

☆☆

NATIONAL HEARING WEEK

October 20-26, 1940

The week of October 20-26 has been designated as National Hearing Week. The work of the American Society for the Hard of Hearing merits careful consideration at this time. Our own Doctor Austin A. Hayden, for so many years secretary of the Board of Trustees of the American Medical Association, at the time of his death was president of the American Society for the Hard of Hearing. Doctor Frederick N. Sperry of New Haven was president of the same society in 1935-1936.

It has been said that there are over 30,000,000 children in our public schools and it is conservatively estimated that of these 1,600,000, or about 6%, have marked hearing losses. Also that about 2% of all school children have hearing losses sufficient to need special training in order to acquire an education. Some states require yearly hearing tests after the fourth grade. In Connecticut there is no testing requirement. The State Department of Education has a Group Audiometer which is loaned and is used principally in the small towns. Several of the cities have audiometers of their own.

The two great helps for the hard of hearing are lip reading and the electric hearing aid. The modern improved electric hearing aid has literally brought back to many of the hard of hearing the desire to live. It is not perfect but it is being constantly improved. Soon instruments will be made to fit every hearing need. Two per cent of all school children need help by the teaching of lip reading. The hard of hearing children of a school should have a teaching period with a special teacher at least twice a week and should spend the remainder of the time with normal children where they would put into practice their special instruction. Then there are certain drugs which have been found to have a deleterious effect upon the hearing of the newborn, — quinine, the salicylates and alcohol, — when administered to the pregnant woman in sufficiently large quantities.

☆☆

MILITARY MEDICINE NUMBER OF OTHER STATE JOURNALS

Two State Journals have published Military Medicine numbers, New York (July 15) and Indiana (September). Both present the various problems of modern warfare as they affect the practice of medicine in combat forces. *The New York State Journal of Medicine,* in an editorial entitled "Protecting Insurance in War time," makes a venturesome expedition into a field in which more authoritative opinion may be obtained here in Connecticut. We shall have more to say about this subject in a later issue. *The Journal of the Indiana State Medical Association* in its special issue is interesting and informative and gives evidence of an active and progressive State organization.

☆☆

LADY DRIVERS

(For Home Consumption)

Apropos of the interest in the program to cut down highway accidents is the announcement by Professor Harry R. DeSilva that lady drivers are not as bad as they are thought to be.

Doctor DeSilva is a research expert in traffic control at Yale University. He has just finished a study of 3000 motorists picked at random from Connecticut drivers in an effort to find out how much there is to the popular belief that women are far worse drivers than men.

Women drive about one half as much mileage as men but they get into only one third as many accidents. Doctor DeSilva is certain that women are safer on the highway and that their low accident experience is not simply because there are fewer women driving.

In the country as a whole in 1939 automobile accidents took nearly 33,000 lives. In these accidents only 6.6% of the drivers involved were women.

These thoughts may not be very comforting when you are following a lady driver who is shifting from lane to lane with her hand sticking out of the window in a vague sort of signal which you finally determine to be an effort on her part to see if it is raining, but they are facts just the same. C. B.

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Paevex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

County Secretaries Conference

The semi-annual conference of the County Secretaries was held at the State Office on September 18th. There were present Doctors: Booe, Fairfield County; Gilman, Windham County; Oberg, Hartford County; McDonnell, New Haven County and Walker, Litchfield County. Absent, Doctors: Burke, Tolland County; Russman, Middlesex County; Wies, New London County. The conference was presided over by the President, Doctor Landry, and discussions were presented on Society finances and dues collection by the Treasurer, Doctor Campbell; the acquisition of new members by Doctor Miller, and medical preparedness in Connecticut by Doctor George M. Smith, State Chairmen on Medical Preparedness.

Medical Preparedness

The county chairmen on medical preparedness met for their first conference on August 28th. There were present: George M. Smith, H. Bertram Lambert, Donald B. Wells, Francis A. Sutherland, George A. Elliott, Ralph E. McDonnell, Daniel Sullivan, Donald M. Beckwith, Edward J. Ottenheimer, Creighton Barker. The State's preparedness program as it has developed to date was discussed and the duties of the county chairman outlined. The committee voted to distribute the postcard questionnaire which has now been sent, and members who have not returned the card are urged to do so.

Public Health Committee

The Public Health Committee met on September 9th at a long and interesting meeting to consider the standards and regulations for the consulting services that are being developed in the Children's Bureau of the State Department of Health. The Chairman, Doctor Joseph H. Howard, appointed a sub-committee consisting of, Chairman Oliver L. Stringfield, Luther K. Musselman and Howard S. Colwell, to report back to the Committee on the subject of birth control legislation as was prescribed by the House of Delegates at its annual meeting in May.

Automobile License Plates

The Commissioner of Motor Vehicles of the State of Connecticut has available a number of automobile license plates bearing the letter designation, M.D., with numerals. The Commissioner is limiting the issuance of these markers to physicians. Members of the Society who would like to exchange their present markers for one of these are invited to communicate with Michael A. Connor, Commissioner of Motor Vehicles, Hartford, Connecticut.

Meeting of the Tumor Committee

The Tumor Committee under the chairmanship of Doctor Charles L. Larkin met in New Haven on Tuesday, September 17th, and discussed and approved the Articles of Association seeking incorporation of the Connecticut Committee for Tumor Study and the Articles of Agreement with the American Society for the Control of Cancer.

Industrial Health Section

The Industrial Health Section met in New Haven on September 18th under the chairmanship of Doctor Eugene Meschter and discussed and perfected plans for the survey to be carried out in cooperation with the State Manufacturers Association.

COUNCIL RESUMES MEETINGS

The Council resumed its regular monthly meetings on September 18th after a summer recess. All members of the Council were present and action was taken upon the following:

1941 Annual Meetings

The 149th Annual Meeting of the Society will be held in Bridgeport on May 21, 22nd. The House of Delegates will meet on Tuesday, May 20th.

Mid-Winter Dinner

It was voted to continue the custom of the last two years and have a mid-winter dinner of the Society in New Haven early in 1941. The program for this meeting is to be arranged by the Society's Program Committee.

Medical Preparedness Activities

The Council approved the procedures of the State Committee on Medical Preparedness to date and voted to authorize reasonable expenditures for the Society's activities.

Tumor Committee

The Council approved the steps taken by the Society's Tumor Committee to effect its working agreement with the American Society for the Control of Cancer.

Commercial Exhibit

The Council approved the appointment of Doctor John H. Bumstead to continue as the director of the commercial exhibit to be held in connection with the 1941 Annual Meeting.

Dues Collection 1941

A statement of the collection of dues from the County Associations for the year 1941 was presented by the Treasurer.

STATEMENT OF DUES

Counties	*Total Members*	*Dues Paid*	*Dues Unpaid*
Fairfield	368	230	138
Hartford	532	380	152
Litchfield	75	61	14
Middlesex	65	47	18
New Haven	510	362	148
New London	116	73	43
Tolland	17	14	3
Windham	40	32	8
Totals	1723	1199	524

⁂

STATE CONFERENCE ON HIGHWAY ACCIDENTS

There are fourteen or fifteen thousand people injured in the State of Connecticut in highway accidents each year; of these many die. From time to time and from many sources there have come efforts to combat this hazard. Some members of the State Medical Society have been active in this connection, particularly Doctor Robert M. Yergason of the Fracture Committee of the American College of Surgeons; Doctor Edward H. Crosby, Chairman of the First Aid Committee of the Hartford Chapter of the American Red Cross; and Doctor Charles W. Goff of Hartford. It was largely through their efforts in cooperation with Mr. Fred W. Orr, Secretary of the Connecticut Chamber of Commerce, and Professor S. Willard Price, Director of University Extension, University of Connecticut, that a statewide conference of persons and groups interested in the subject of highway accidents was held at the University of Connecticut on September 12th. There were fifty persons in attendance representing State Departments of Motor Vehicles, Education, Insurance and Police; and the Manufacturers Association, the State Grange and the State Highway Safety Commission. The Connecticut State Medical Society was represented by the President; the Secretary; Doctor Yergason, Doctor Goff, Doctor Crosby of Hartford; Doctor Gilman of Storrs and Doctor Grillo of Hamden.

The conference was presided over by Professor Price and brief papers discussing various phases of the highway accident problem were presented by Doctor Yergason; Lieutenant Ralph Buckley of the State Police; Mr. William Green, Director of Safety, State Motor Vehicle Commission, speaking in the absence of Commissioner Connor; Doctor Crosby and Major Vernon S. Morehouse, Chairman of the Highway Safety Commission.

Major Morehouse in his address suggested a program for the State which would include first aid extension courses to be given by the University of Connecticut, an annual first aid competition to be held in various parts of the State and the establishment of courses in first aid in all of the junior and senior high schools in the State.

At the close of the meeting Mr. Orr of the State Chamber of Commerce presented a resolution, which was accepted, authorizing the Chairman to appoint a state wide committee for the purpose of studying the problem of highway accidents and to direct a program of prevention and instruction.

The committee was appointed as follows:

S. Willard Price, Connecticut University
Michael A. Connor, Commissioner of Motor Vehicles.
William J. Cox, Highway Commissioner
Alonzo G. Grace, Commissioner of Education
John C. Blackall, Insurance Commissioner
Charles A. Morris, Commissioner of Aeronautics

(*Concluded on Page 636*)

Programs—Semi-Annual County Association Meetings

Fairfield:

Wednesday, October 2, Laurel Heights Sanatorium, Shelton

Hartford:

Tuesday, October 22, Masonic Hall, Manchester.

1.00 p.m. Golf — Manchester Country Club
4.30 p.m. Business Meeting — Masonic Hall
6.00 p.m. Dinner — Masonic Hall
8.00 p.m. Speaker — Francis G. Blake, M.D., Sterling Professor of Medicine, Yale — "Chemotherapy with Sulfapyridine and Sulfathiozole."

Litchfield:

Tuesday, October 1, Bantam Lake (by invitation)

6.30 p.m. Dinner
Business Meeting
Speaker — Francis G. Blake, M.D., Yale University School of Medicine

Middlesex:

Thursday, October 10, Edgewood Country Club, Cromwell.

4.00 p.m. Business Meeting
Speaker — H. M. Zimmerman, M.D., Professor of Pathology, Yale — "Clinical Problems in Intercranial Neoplasia of Interest to the General Practitioner."
6.00 p.m. Dinner — Following the dinner Stanley H. Osborn, M.D., State Health Commissioner and member of the National Committee on Medical Preparedness, will informally discuss medical preparedness plans.

New Haven:

Thursday, October 24, Waterbury Country Club, Waterbury

12.00 noon Lunch
4.00 p.m. Business Meeting
Speakers — Colonel Charles W. Comfort; Lieutenant Colonel Nylen, M.C., U.S.A.; Lieutenant Commander W. M. Peabody, M.C., U.S.N.; Stanley H. Osborn, M.D., Member National Committee on Medical Preparedness; George M. Smith, M.D., Chairman State Committee on Medical Preparedness.
Subject—Medical Military Preparedness and Defense in New Haven County. (After-dinner speaker to be announced later)

New London:

Thursday, October 3, Uncas-on-Thames, Norwich

6.30 p.m. Dinner
Speakers — Chester Keeffer, M.D., Boston, and Howard M. Clute, M.D., Boston, Mass.
Subject — Symposium on Gall Bladder Disease

Tolland:

Tuesday, October 15, Old Homestead Inn, Somers

6.30 p.m. Dinner
Business Meeting
Speaker — George M. Smith, M.D., Pine Orchard
Subject — Medical Preparedness in Connecticut

Windham:

Thursday, October 17, Kingswood Hotel, Danielson

12.30 p.m. Dinner
Business Meeting
Speaker—James C. Fox, M.D., New Haven
Subject — Some Problems of Neurology Confronting the General Practitioner.

Connecticut Hospital Association

NEW LONDON HOSPITAL ADOPTS COMMUNITY FUND PLAN WHICH SIMPLIFIES CONTRIBUTION PROBLEM

By the adoption of a Community Fund plan the Lawrence and Memorial Associated Hospitals of New London has succeeded in solving the problem of contributions by employees to various local charities and other group donation beneficiaries.

In years past every time the Girl Scouts or Boy Scouts or Associated Charities, Visiting Nurse Association, etc., etc., put on a drive for funds (New London does not have a community chest), the hospital personnel were solicited for contributions. Also, when a member of the personnel had a death in his family usually a collection was taken up to send flowers. The result was that nearly every week in the year employees were asked to contribute 10 cents or 15 cents for some purpose. This was annoying to the employees and was a considerable chore for whoever had to solicit the contributions and keep track of them.

About four years ago the plan now in effect was started and it has worked most satisfactorily. Every member of the professional personnel signs an authorization, by which the hospital deducts a certain amount from his salary quarterly. This money is deposited in a checking account called the "Community Fund Account."

Yearly the employees meet and elect officers, consisting of a Chairman, Secretary, Treasurer and Executive Committee. On the Executive Committee are representatives from the various departments. Those participating in the fund include not only the nursing personnel, but also office employees, laboratory technicians, and heads of departments, etc. Personnel of the dietary, housekeeping, laundry and maintenance departments do not participate.

There is a standing list of charities to which contributions are made practically automatically. On special occasions, where a precedent does not exist, the Executive Committee is consulted and decision is made whether or not to give and how much. The plan will have been in operation four years on December 1, 1940, and in that time a total of $1,158.75 has been contributed.

The plan is simple, effective, does not entail very much work for anyone and can be recommended for similar situations.

IMPROVEMENTS AT NEW BRITAIN HOSPITAL

New Britain Hospital has installed a new Destructor for the burning of rubbish and also a new 200 horse power Scotch Marine boiler.

MISS NIVISON IN BOSTON

Miss Helen T. Nivison, Superintendent of the Griffin Hospital in Derby, is at the Institute in Boston during September where she will also receive a degree from the College of Hospital Administrators.

ITEMS OF INTEREST FROM THE BRIDGEPORT HOSPITAL

The Bridgeport Hospital School of Nursing has begun its fall program for a student body of 154. A group of 32 preliminary students entered on September 4th, and are very busy with their classroom program.

Miss Bessie Hatch has been appointed Clinical Instructor to fill the vacancy caused by the resignation of Miss Ballou.

The size of the school has been increased somewhat during the past year because it was felt that the need for nurses is becoming greater, due to the fact that more attention nationally is being given to health problems. Therefore, many government institutions as well as private have increased their facilities for the care of patients, making constant demands upon the nursing profession to supply graduate nurses for these institutions.

Mr. Blair M. Patterson, Night Superintendent at the Bridgeport Hospital since 1937, has accepted the superintendency of the

Elyria Memorial Hospital of Elyria, Ohio. Mr. Patterson's successor is Mr. H. Edwin Towner. Mr. Patterson and Mr. Towner received their training at the Ruptured and Crippled Hospital in New York City, an institution where Mr. Oliver H. Bartine was formerly the superintendent.

The following report submitted to the Board of Directors by Oliver Bartine, Administrator of the Bridgeport Hospital, is a fine example of information submitted by the executive head of an institution. It gives the Board of Directors a complete picture of the hospital for a period of three months and, incidentally, Mr. Bartine is to be congratulated on the excellent showing of his institution.

To the Members of the Board of Directors:

In presenting the quarterly report for the period ending June 30, I wish to call your attention to the fact that for the first six months in 1939 the number of patients treated at the hospital was 5,531, and they received 58,842 days of care. The number of patients treated during the same period in 1940, was 5,624, and they received 63,621 days of care. This shows an increase of 93 patients, and an increase of 4,779 days of care. The average length of stay per patient in 1939 was 10.6 days, and in 1940 it was 13 days. This would clearly indicate that the congestion in the hospital is not due to the number of admissions, but is the result of the increased length of stay per patient. The following percentage of occupancy is most interesting and shows very definitely the real activity of the hospital during this period:

Percentage of occupancy

	1939	1940
Private Rooms	72.1%	80.3%
Semi-private	84.8%	91.2%
Wards	90.5%	95.5%
Bassinets	58.2%	65.2%

The percentage of occupancy of all beds in 1939 was 81.2% and in 1940 it was 87.3%, which is considered by hospital authorities to be a very high percentage of occupancy.

The income for the first six months of 1939 was $245,471.62, and it was $276,741.71 for the same period in 1940. The cost of maintenance for the first six months of 1939 was $295,695.82, and it was $305,455.17 for the same period in 1940. The cost of maintenance per patient per day for the first six months in 1939 was $5.03 and it was $4.81 for the same period in 1940. The operating deficit for the first six months in 1939 was $50,224.20 and for the same period this year it was $28,713.46. The daily average cost of raw food per individual supported for the first six months in 1939 was $.378, and for the same period in 1940 it was $.372.

The statistical and financial figures appear most gratifying, and I would suggest that you make a careful study of the comparative statistics that are attached to this report.

The activities of our institution clearly indicate the necessity of expansion in a number of directions. First, I shall mention the great need of improved and more adequate operating facilities. The expansion of this unit would enlarge Wood Ward, and provide storage space for general supplies in the basement. In connection with such a building I would recommend an additional floor to include the Laboratory and the X-ray Department. This improvement would allow additional patients in Wood Ward and more private patients on Perry II. The space at present utilized by the X-ray Department would be used for patients and the expansion of other departments of the institution.

Another real need of our hospital is the enlargement of the present interne's quarters. With the growth of the institution, an increased number of internes is necessary. Plans have already been drawn up for such an expansion of the roof of the North West Building.

With the rapid growth of our hospital, this report would not be complete without reference to the great necessity of completing the original plans for the Elizabeth Oliver Home for Nurses. With such a building, the nursing department would be housed in one building, which would include modern class rooms.

During the quarter, a new tank was installed in the x-ray developing department at a total cost of $1,357.

In July, many repairs were made in the machinery in our ice-making plant, amounting to $457. At present, we are replacing many of the steam lines in the Marsh Building and providing adequate shut-off valves. The repairs and painting at the hospital are continuing on a very large scale. During the winter, many leaks developed in the slate roofing of the institution which were repaired during the past two months. An additional parking space has been provided in the rear of the hospital grounds. As you all know, the number of cars arriving at the hospital is increasing rapidly, and this additional space was most imperative due to the greater number of cars belonging to the Staff and personnel. At present, the painters are busily engaged in exterior work including the fire escapes. The retaining wall around two sides of the Nurses' Home has been entirely repaired and painted this past week.

On Friday, August 2, 1940, Doctor H. LeBaron Peters passed away. Doctor Peters was appointed Bacteriologist at the Bridgeport Hospital in 1912. He was an outstanding physician and consultant in whom his colleagues had infinite trust and confidence, and his passing has been a great loss to the hospital and to his multitude of friends. Doctor Peters was most co-operative with the Administration, and his advice was freely and cheerfully given on many occasions.

On Sunday, May 12, the Reverend Fred Hoskins conducted the Bridgeport Hospital Sunday services at the United Church. There was a very large attendance by the Officers and Board of Directors of the Hospital, the Staff, the members of the Women's Staff for the Children's Ward, the Nursing Department and personnel. Doctor Hoskins gave a splendid sermon stressing the fine work of the institution and the needs of our hospital.

National Hospital Day was observed on May 12, and the hospital was open for inspection by the public on that day between the hours of two and five o'clock in the afternoon. Over 1,700 visitors were greeted and escorted through the buildings by the members of the Women's Staff for the Children's Ward, the Junior League, the Nurses' Alumnae Association and the personnel. An excellent article on National Hospital Day, prepared by Mr. Senior, our President, appeared in the local papers.

On May 1, Miss Mildred A. Richardson, Assistant Superintendent of Nurses, was appointed Acting Director of the School of Nursing. This appointment was necessary, due to the illness of Mrs. Ethel P. Clarke.

The Nurses' Commencement exercises were held at the Warren Harding High School on May 28, at which time thirty-five nurses were graduated. Mr. Samuel P. Senior presided. A splendid address was given by Doctor Remsen B. Ogilby, President of Trinity College, Hartford. The Reverend Frederick L. Barry offered the Invocation and Benediction. Selections were rendered by the Choral Club under the direction of Miss Grace Laing. A reception followed at the Nurses Home which the parents and friends of the students attended.

On July 1, a letter was received from Mrs. Prentiss B. Gallup, President of the Junior League, stating that "at the March Meeting of the Junior League of Bridgeport the contribution to the Occupational Therapy Shop was decided on for the fiscal year of April 1, 1940 to March 31, 1941. In accordance with the national policy of turning over a well running project to its own organization, it was decided to reduce further our financial support. As you know, we are giving all possible financial support to the Crippled Childrens Workshop, our new project. It was voted to limit the amount to be used for materials to $650, to reduce the Christmas fund to $30, thereby eliminating the Christmas gifts. We shall, however, continue with the radio maintenance." Mrs. Gallup further stated that Mrs. Francis Simpson would be temporary Chairman of the Occupational Therapy Shop Volunteer Committee.

On May 23, the Veterans of Foreign Wars, through Mr. Harry McCrealis, presented an oxygen tent to the hospital. This contribution was a splendid addition to our oxygen therapy, and as you all know is of great value to our patients. This gift is very highly appreciated by the hospital, and we again wish to express our gratitude to the Veterans of Foreign Wars.

On May 28, a letter was received from Mr. Sanford Stoddard relative to a trust set up by Dwight Wheeler for the benefit of Stephen H. Castell which on his death came to the hospital, in the amount of $6,545.60.

Mr. Herman K. Beach, Chairman of the Building Committee, will report upon the activities of that Committee during the past quarter.

Mr. Frederick Rhodes, Chairman of the School of Nursing Committee, will present a report of the activities of the Nursing Department.

In conclusion, I wish to express my appreciation to the President of the Hospital, the members of the Board of Directors, the Staff and personnel for their kind assistance and co-operation during the past quarter. With their splendid help it has been possible to present such a gratifying report at this time.

Respectfully submitted,
Oliver H. Bartine, Superintendent

COMPARATIVE STATISTICAL RECORD FOR FIRST SIX MONTHS

	1939	1940
Patients in Hospital at beginning of year	286	268
Patients admitted during the six months	5,245	5,356
Total No. of Patients Treated	5,531	5,624
Patients discharged "Recovered"	1,723	2,020
Patients discharged "Improved"	3,146	2,995
Patients discharged "Unimproved"	72	82
Deaths	241	202
Patients remaining in hospital at end of 6 months	349	325
Total	5,531	5,624

	Pts. Tr.	Days Care	Pts. Tr.	Days Care
Private Room Patients	673	6,788	757	7,614
Semi-Private Patients	835	9,530	843	10,310
Ward Patients	2,573	27,820	2,701	30,699
Ward-Patients-City	666	6,892	490	6,204
New Born	784	7,812	833	8,794
Total	5,531	58,842	5,624	63,621

	Days Care	%	Days Care	%
Paid and Part-Paid Service	35,495	60.3%	42,123	66.2%
Free Service	23,347	39.7%	21,498	33.8%

	1939	1940
Income for Six Months	$245,471.62	$276,741.71
Income per day	1,356.19	1,520.56
Cost of Maintenance for Six Months	$295,695.82	$305,455.17
Cost of Maintenance each pt. per day	5.03	4.81
Cost of Maintenance per day	1,633.68	1,678.32
Operating Deficit	$50,224.20	$28,713.46
Ratio earnings to cost	83.%	90.%
Expense per bed occupied for six months	$909.83	$873.98
Income per bed occupied for six months	755.29	791.82
Deficit per bed occupied for six months	154.54	82.16
Expense per bed occupied for one day	$5.03	$4.81
Income per bed occupied for one day	4.14	4.34
Deficit per bed occupied for one day	.85	.47
Expense per patient-average for period	$53.46	$54.31
Income per patient-average for period	44.38	49.21

	1939	1940
Deficit per patient-average for period	9.08	5.10
Cost of Food for Six months	$53,046.14	$56,270.57
Daily Average Cost of Raw Food per individual supported	.378	.372
Daily Average Cost of Food per patient supported	.901	.884
No. of Meals Served	420,840	445,467
Average No. of Meals Served Daily	2,326	2,446
Daily Average No. of Officers, Nurses and Employees	468	482
Daily Average No. of Officers, Nurses and Employees (meals)	417	431
Daily Average No. of Special Nurses (meals)	23	26
Daily Average No. of Patients	325	349.5
Daily Average No. of Visitors	10	10
Daily Average No. of Individual Persons Supported	775	816
Total Days Support to all Individuals, (meals) Personnel and Patients	140,285	148,490
Daily Average Admissions	28.9	29.4
Daily Average Discharges	28.6	29.1
Average No. of Patients Admitted Daily to		
Private Rooms	3.5	3.9
Semi-Private	4.3	4.3
Wards	16.9	16.7
Nurseries	4.1	4.3
Average No. of Patients Treated Daily in		
Private Rooms	37.6	41.8
Semi-Private	52.6	56.6
Wards	191.7	202.7
Nurseries	43.1	48.3
No. of Children Admitted	708	691
Average Length of Stay—All Patients	10.6	13
Percentage of Occupancy		
Private Rooms	72.1%	80.3%
Semi-Private	84.8%	91.2%
Wards	90.5%	95.5%
Bassinets	58.2%	65.2%
ALL BEDS	81.2%	87.3%
Total Bed Capacity	400	400
No. of Out-Patients	3,754	3,926
No. of Births	755	795
No. of Stillbirths	13	24
No. of Deaths	241	202
No. of Autopsies	112	60
No. of Operations	1,873	1,910
No. of Laboratory Examinations	53,923	52,456
No. of Radiographic Examinations	1,791	1,803
No. of High Voltage X-Ray Treatments	796	619
No. of Radium Treatments	123	104
No. of Physiotherapy Treatments	1,059	1,188
No. of Emergency Room Treatments	2,999	2,989
No. of Pharmaceuticals Compounded and Dispensed	8,468	11,278
No. of Charged Medications	3,909	5,788
Refills on Same	2,591	3,059
No. of Free Prescriptions	1,117	1 647
Refills on Same	851	784
Highest Census	392	413
Lowest Census	259	283
No. of T. and A. Clinic Cases Admitted	301	270
No. of Patients Discharged Against Advice	137	112
No. of Miscellaneous Accident Cases Admitted	295	246
No. of Industrial Hazard Cases Admitted	81	146
No. of Ambulance Cases	1,011	778
Admitted	889	681
Treated as out-Patients	122	97
No. of Electrocardiographic Examinations	167	1,208
No. of Examinations — Prenatal Clinic	1,270	1,033
No. of Out-of-town Cases	1,350	1,352

SICK TIME ALLOWED TO EMPLOYEES AT GREENWICH HOSPITAL

The Greenwich Hospital has recently made a thorough study of the problem relating to sick time allowance for employees and, as a result, the following rule has been instituted:

"Employees who are members of the Associated Hospital Service (3 cents-a-day-plan) who are hospitalized and the expense of that hospitalization is paid for by that organization, the employee receives his or her salary for the period. For all employees who are not members of the Associated Hospital Service or for employees whose hospital expenses are not accepted by the Associated Hospital Service, the employee is hospitalized without charge, but receives no salary for the period.

Employees are allowed a total of fourteen days in each year of sick time with salary, but must furnish the hospital with a doctor's certificate. This sick relief is for minor illnesses where hospitalization is not required."

This rule applies to all employees regardless of length of employment. We have an arrangement with the Associated Hospital Service whereby it is possible for all new employees to make application for membership in this Plan after a thirty-day period of employment. The employees pay the Associated Hospital Service for membership, which is deducted monthly from their salaries.

The response of the employees was very gratifying as we found that more than eighty-five per cent entered the Plan in order that they might receive the benefits of this rule. The hospital will benefit by the amount received from the Associated Hospital Service to the extent of approximately $3,000 per annum, based on the number of hospital days the hospital has furnished employees heretofore.

BOARD OF TRUSTEES

August 28, 1940
1:30 P.M.

A Meeting of the Board of Trustees, held at the Hartford Hospital on above date and time, President Dr. Wilmar Allen presiding.

Members present: Miss Griffin, Mr. Davidson, Mr. Bartine, Dr. Buck, and Mr. Sweeney.

Dr. Geeter, Chairman of Compensation Rate Committee

Dr. Mason of Waterbury Hospital

Mr. James Hamilton of New Haven Hospital

Doctor Geeter reported for the Special Committee stating that returns from member hospitals in answer to the proposal of a uniform rate of $4.75 for room and board of compensation cases was acceptable to 33 hospitals and not acceptable to two other hospitals who proposed a higher rate and further consideration of the agreement for extra charges.

Much discussion ensued involving the relation of extra charges and the fact that in prior discussions with the insurance representatives, no reference to any proposed change in the status of the present published rates for extra services had been mentioned.

In view of the approaching meetings of institutes and the convention, and the absence of Doctor Geeter, it was agreed that President Allen would notify the representatives of the Insurance Carriers that a unanimous decision on the room rate had not been agreed upon; that the factor of inclusion of tariff for extras at this time had complicated the situation; further discussion by the Board of Trustees with its members, and the suggestion that for the present, consideration be given to reaching an agreement on the room rate and allow the present published rates for extras to be accepted.

The Secretary read a communication from Director Hancock of the Lawrence & Memorial Associated Hospitals extending an invitation to hold the fall meeting of the State Association at New London.

> VOTED: To accept the offer to hold the fall meeting at New London. The Secretary was requested to acknowledge the invitation and state that the date of the meeting would be decided later.

Following discussion, it was deemed advisable to include in the agenda of the fall meeting, the suggestion for centralization of the annual meeting of the Association. Resolutions Committee requested to give this matter consideration.

Doctor Martha Clifford and Doctor Souther of the State Board of Health appeared before the Committee and outlined the proposition for development of Maternal and Pediatric Consulting Service under the auspices of the State Department of Health. Following several inquiries from members of the Board and due to lack of detailed information pertaining to workings of the Proposal, the Board assured the representatives of the State Department of their interest in the proposition and tabled the matter for further discussion.

Secretary reported on the National Preparedness Survey stating that 35 Questionnaires had been sent out to member hospitals on July 14. 22 replies have been received to date, 14 stating no facilities available and 15 hospitals reporting training facilities available to some extent for technical workers.

The Secretary also reported that member hospitals had been notified of the issue of the Book of Hospital Statutes and orders solicited.

To date, 22 hospitals have ordered 29 copies which have been shipped direct from the publishers in Hartford, and one set of unbound leaves has been included with each order.

Cash in the sum of $125.00 received by the Secretary has been forwarded to the Treasurer.

> VOTED: That the Secretary be authorized to send a complimentary copy of the Hospital Statutes to Judge Arnon Thomas of New Haven.
>
> VOTED: To authorize the Treasurer to pay the Fox Company, Publishers, in full as per bill rendered and approved.

Mr. Bartine brought to the attention of the Board the action of the New Haven Hospitals and Mr. Thomas in securing a decision relative to the financial responsibility for County charges in hospitals, the decision favorable to hospitals.

The Secretary was requested to send a note of appreciation for this action to the New Haven Hospitals and to Mr. Thomas.

It was brought to the attention of the Board that no action had been taken relative to a contribution towards the publicity expenses of the National Convention at Boston through the New England regional committee.

> VOTED: To appropriate the sum of $25.00 from the Connecticut Hospital Association as a contribution towards the publicity program of the National Convention.

Discussion ensued pertaining to a suggestion that a recommendation be made for the formation of an Advisory Committee from the Hospital Association to cooperate with the Plans for Hospital Care operating in Connecticut effecting hospital problems. No action was taken. The suggestion was approved that member hospitals of the Plan take such action under consideration rather than the Association.

A communication was read from the Secretary of the American Hospital Association in answer to our inquiry

(Concluded in Vol. IV No. 11, November 1940)

National Conference on Medical Preparedness

Physicians from all parts of the country met in Chicago on September 20 to plan and discuss the medical phases of the national preparedness effort. Connecticut was represented by Commissioner of Health and member of the National Committee, Stanley H. Osborn, George M. Smith, State Chairman on Medical Preparedness and the Executive Secretary of The Connecticut State Medical Society.

The agenda for the conference moved swiftly and authoritatively because of the presence of representatives of the Federal services including Surgeon General Parran of the United States Public Health Service; Colonel Albert G. Love, Medical Corps, United States Army; Lieutenant Colonel Charles B. Spruit of the Selective Service Board and Captain Dallas G. Sutton, Medical Corps, United States Navy.

Since the beginning of the preparedness effort the American Medical Association has been advocating an official body to coordinate medical and health measures. As the Chicago conference opened announcement of the accomplishment of that objective was made. There is to be a Committee on Medicine and Health of the National Defense Council under the Chairmanship of Doctor Irvin Abel, other members of the Committee are the Surgeon General of the Army, Navy and Public Health Service and Doctor Lewis H. Weed, Chairman of the Medical Section of the National Research Council. This coordinating committee will have authority over all plans and policies in the field of health and medical service.

Most of the morning session was occupied by discussion of the operation of the medical phases of the Selective Service Law. In general the organization for that purpose will be exactly as anticipated by the Preparedness Committee of the State Medical Society and which has been under development here for some weeks.

There will be local Selective Service Boards in various localities, probably about seventy in this State. To each of these one or more medical examiners will be assigned. These physicians will not be members of the Boards, their function will be to examine, define, interpret and recommend. Physicians may serve as members of local Boards as any other citizen but when so serving they may not be medical examiners.

The Connecticut State Medical Society has been asked to suggest the names of physicians to serve as examiners who will later be recommended for appointment by the Governor and appointed by the President of the United States. Members of Boards and medical examiners attached to them will serve without compensation; necessary supplies, equipment and clerical assistance will be furnished.

There is as yet no official ruling on the subject but the policy to recommend as medical examiners only those physicians who are over the selective service age (36) has been generally adopted and the Connecticut committee will, for the present at least, follow that policy.

Over the local boards will be a number of Medical Advisory Boards composed of specialists in various fields. These Boards will be based on hospitals in a number of districts, probably five, and to them draftees will be sent for special examinations. The physicians for these Advisory Boards will be suggested by the State Medical Society and insofar as possible diplomates of the National Specialist Examining Boards will be utilized and appointed in the manner provided for medical examiners. They will also serve without compensation but required laboratory and x-ray procedures and similar services will be paid for.

The anticipated load on each Board was explained by Lieutenant Colonel Spruit and will be far less than in 1917-1918. According to Lieutenant Colonel Spruit, based on a gross quota of 400,000 and an estimated 6500 Boards, each Board will have to supply about sixty men. Based on previous experience with rejections it will be necessary to examine ninety men to get that sixty and with the present plan for induction each Board will have to provide between twenty and thirty men per month. Present estimates of Connecticut's participation are: Number expected to register, 212,755; expected Class 1 rating, 70,925; quota to be furnished in first 400,000, 5156; quota in first call, 980.

Many questions were asked concerning the status of various classes of physicians such as reserve officers, public health officers, internes and hospital residents. Careful and understanding consideration is being given to these questions by the Army. In general it may be said that internes who are called up in the selective service will be deferred until they have completed one year of internship, under certain circumstances two years will be allowed. After being inducted into the service they will be given the opportunity to take examinations for a commission in the Medical Officers Reserve Corps. Graduates of substandard medical schools and cultists are not to be included in these provisions.

The status of physicians now commissioned in the reserve is made quite clear under Senate Joint Resolution 286.

> "That during the period ending June 30, 1942, the President be, and is hereby authorized from time to time to order into the active military service of the United States for a period of twelve consecutive months each, any or all members and units of any or all reserve components of the Army of the United States . . . with or without their consent, to such extent and in such manner as he may deem necessary for the strengthening of the national defense.
>
> Sec. 3(e) Any member of any reserve component of the Army of the United States below the rank of Captain who is ordered into the active military service of the United States pursuant to this joint resolution, who has any person or persons dependent solely upon him for support, and who has no other means of support except the wages, salary or other compensation for personnel services that he earns, may resign or shall be discharged upon his own request made within twenty days of the date of his entry into such active military service."

Public health officials and other physicians may be exempted or deferred by the local Selective Service Board on the basis of "protection of the public health, safety and interest."

Many other topics were presented before the conference including the progress of the American Medical Association's survey of medical personnel, the relation of the draft to teachers and students in medical schools, plans for the protection of the practices of physicians in federal service and the provision of a certificate and badge for physicians doing patriotic services outside the organized forces.

Following the conference there was a meeting of the State Chairmen from each of the New England states which comprise the First Corps Area. Doctor Walter Phippen of Salem, Massachusetts, member of the National Committee for the First Corps Area, presided. This Corps Area is of unusual importance in the defense industry and in a vulnerable location and it is essential that medical preparedness plans for the Area be carefully made and well coordinated. Later meetings of the State Chairmen in New England are contemplated.

☆☆

PHYSICAL THERAPY IN PREPAREDNESS

The editor of the *Archives of Physical Therapy* (*July* 1940) believes the Preparedness Committee of the American Medical Association in the questionnaire recently sent out has overlooked the value of physical medicine in war owing to the stress of the existing emergency. The necessity for the rehabilitation of those left incapacitated from wounds or injuries was realized by both General Gorgas and his successor in the office of Surgeon General of the Army during and soon after World War I. Organized medicine has recognized the status of physical medicine and placed it among the medical specialties. Most class A medical schools provide extensive courses in physical medicine and most hospitals contain a special physical therapy department.

Today there are hundreds of ethical and competent members of the American Medical Association and its constitutent societies who are well trained as physical therapeutists, a situation which did not exist twenty five years ago. Rehabilitation of our own troops must be provided for and the personnel for such is available. The American Congress of Physical Therapy believes that the Committee on Preparedness of the American Medical Association will realize this oversight and take steps to provide for proper listing of trained physical therapeutists.

Body Protection for the Soldier

Body armor for the soldier is becoming a problem of concern to nations engaged in combat. Just what protection the Germans are using, if any, is not known. The British say that the Germans shock troops are protected and from America comes the information that before the war efforts were made to induce a certain inventor to place his armor at the disposal of the German staff. Some believe the English helmet inferior to the German; others disagree.

Kenneth M. Walker, F.R.C.S. (*Proc. Royal Soc. Med. July* 1940) interested himself in this problem and has recorded his observations made during World War I. He noted that frequently men in the front line were killed by tiny splinters of grenade and shell entering the front of the chest, splinters that ripped open the heart, or the roots of the great blood vessels, and caused almost instantaneous death. Such splinters often had very low penetrating power, and as the pictures in the daily press showed many men had experienced miraculous escapes from death through carrying in a breast pocket such articles as a cigarette case or a New Testament. For every lucky escape, however, there were a hundred deaths, rarely recorded as they almost never reached the casualty clearing stations or even the field ambulances. Walker's investigations revealed that but 3% of the total wounded admitted to the casualty clearing stations were suffering from chest wounds. This seeming discrepancy was due to the fact that the great majority of chest wounds are immediately fatal and the sufferers from them die on the battle field.

Warfare in 1940 is even more mechanized than in 1918 so that the objection to armor protection for the body because of its added weight, no longer holds. The soldier requiring protection no longer marches, he rides in a lorry, on a motor bicycle, on a gun carriage or in an aeroplane. Walker describes a jerkin to cover the whole of the abdomen and chest and weighing only 14 lbs. He claims that it will stand up to projectiles of low and medium velocity, in other words to shrapnel, hand grenades, revolvers, automatic pistols and to an, at present indefinable percentage of fragment of shell and bomb. It will also resist a Tommy gun, but not rifle and machine gun fire much under a range of 1,000 yards. Formerly only steel was considered for such armor. Now materials of about the same tensile strength as aluminum with half its weight can be utilized. The British Air Ministry seems to be keenly interested in body protection while the War Office gives no evidence of any interest.

Walker believes that the initiative in formulating protective armor for all kinds of combat troops must come from the medical profession. Only by a close study of the type of injury from which a particular branch of Service suffers can the necessary means of preventing it be found.

Sir Richard Cruise has invented a visor to prevent injuries to the eye. This visor was moulded so as to fit the inner curvatures of the steel helmet, to which it was attached by rivets. He feels that all helmets should carry this visor attachment as it would prevent small fragments of low kinetic energy from entering the eye, one of the major factors in producing blindness.

Ogier Ward has noted the great increase in wounds of the buttock and back and of the back of the neck, due to crouching because of air attack. He suggests that a curtain of chain mail be attached to the back of the "tin hat" coming down as far as the 7th cervical vertebra.

T. B. Layton is opposed to adding to the weight of equipment and suggests a two ounce protection to cover the area of the heart.

The following resolutions were voted unanimously by the Royal Society of Medicine:—

1. That this representative meeting of the Royal Society of Medicine, after a full discussion of the question, is emphatically of the opinion that the physical protection of the members of the fighting forces can and should be improved by a closer collaboration between the medical profession and the appropriate technical experts of the Admiralty, War Office, and Air Ministry.

2. That this meeting of the Royal Society of Medicine resolves that the Council of the Society be asked to consider the formation of a special committee to this end, according to By-law 21; furthermore, as the matter is, in

the opinion of this meeting, one of extreme urgency and importance, it is hoped that the President may use his emergency powers and approach the Government with the offer of the Society's cooperation at the earliest possible date.

☆☆

REFUGEE CHILDREN IN UNITED STATES

Children from the war zones may now be admitted to the United States under either quota or visitor's visas under a plan approved by the President of the United States and by the departments of State and Justice.

The Children's Overseas Reception Scheme worked out by the Inter-departmental Committee on the Reception of Children Overseas, is confined for the present to school children who are at least 5 years of age and who are not yet 16. It includes arrangements for children of other nationalities living in Great Britain. According to the evacuation scheme the British Government would meet transportation costs for the children to the point of debarkation. Parents contribute toward the cost of transportation, if able to do so. Private arrangements by parents who are able to meet the full expense are encouraged. On July 12 the Ministry of Information announced that the British Government has postponed the scheme for the present, because of reluctance to take the responsibility of sending shiploads of children across the Atlantic Ocean without convoy, but that "children sent apart from the Government scheme will be allowed to leave either at the parent's risk or at the risk of voluntary associations which are arranging for their transport."

Summary of Standards of Care, as prescribed by the Children's Bureau June 28, 1940, are as follows:

1. Agency should be approved by and under supervision of State department of welfare of the State in which it is located.
2. Agency should be fully equipped and qualified for child placing service. Resources of agency should include a well organized and professionally staffed social service department for the selection of foster home.
3. Agency should maintain records of all available information concerning each child and his family.
4. All European children received for care should be placed in family homes of their own religious faith, except where the child's special needs require other forms of care.
5. All children received for care should be assured adequate medical care and health supervision, should attend school until at least the age of 16 years and should not be gainfully employed prior to the age of 16 years. Not more than two unrelated children should be placed in one home.
6. Agency to retain responsibility for each child until he reaches the age of at least 18 years, or has been returned to a parent or legal guardian, or transferred to other care with the approval of the United States Committee for the Care of European Children.

In order to provide necessary funds the National Child Refugee Committee is undertaking a campaign, approved by the President, to raise $5,000,000.

Responsibility for the placement and supervision of children in conformity with the standards of the Children's Bureau will be allocated by the Committee to child caring agencies designated by the Children's Bureau, in consultation with State welfare departments, as equipped to give such service. Information from the central committee and coordination of the work of local public and voluntary agencies for children from war zones are being handled by local information committees appointed by the United States Committee. The local committees have now been appointed in more than 150 cities throughout the United States.

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

(SEE PAGE 2)

Medical Preparedness in Other States

In practically every one of the forty eight states in the Union a Committee on Medical Preparedness has been formed and is now functioning. Some State Societies have accomplished more than others. Here is what a few have done:

Philadelphia County in Pennsylvania

A course for civilian physicians on Medical Preparedness in the Present National Emergency will be given by the Philadelphia County Medical Society at the Society Building, Twenty first and Spruce Streets. With the Philadelphia County Medical Society the course will be sponsored by the following organizations:

The Homeopathic Society of the County of Philadelphia

The Philadelphia County Dental Society

The Keystone Veterinary Medical Association

The W. W. Keen Chapter, Association of Military Surgeons of the United States.

The first meeting was held on September 10, 1940. Other meetings will be held weekly on Thursday afternoons from 4·30 to 6 o'clock, beginning September 19 and continuing for several months. The program for September 19 dealt with the Selective Service Act and the Physician, for September 26 with Non-Combatant Military Hospitals and Installations.

The Philadelphia County Medical Society in one of the few county medical societies in the country which has constantly maintained a standing Committee on National Defense. It was therefore already organized to fit into the program of medical preparedness. It has sent out a questionnaire not only to all its members but to every physician in the City of Philadelphia. At the present time both this Committee and the Committee on Medical Economics are studying the various problems that soon will confront many physicians.

This spring the Army re-established the institution sponsored units of the World War. Evacuation Hospital No. 52—Pennsylvania Hospital and General Hospital No. 20—University of Pennsylvania Hospital and General Hospital No. 28 of Jefferson Hospital quickly came into being, retaining men of the highest professional ability for their commissioned personnel.

California

California has a State Council of Defense, an independent State effort brought into being by Governor Olson, who appointed a committee of fifty citizens to supervise the alignment of California's resources for military needs. On this committee of fifty the medical profession is represented by a single physician, Doctor Charles A. Dukes of Oakland. At Doctor Dukes' suggestion, the responsibility of making nominations for the twenty district boards of medical referees, each composed of seven specialists, was given to the California Medical Association The final recommendations for appointments to these twenty boards will be made to the Federal authorities by the State Adjutant General.

New Jersey

County Committees on Medical Preparedness for War have been appointed by many of the County Societies in New Jersey. The President of each County Society and the chairman of each county committee so far appointed have been furnished with a resume of the activities of the State committee, and other pertinent information which will be of assistance in their county programs. In World War I there were two army hospitals organized by the personnel of New Jersey hospitals, — General Hospital No. 84, sponsored by Elizabeth General Hospital and General Hospital No. 78, sponsored by Newark City Hospital. Their complete reorganization will probably be necessary if they are to become active, according to the Journal of the Medical Society of New Jersey.

Indiana

The House of Delegates of the Indiana State Medical Association last October voted to adopt a resolution offering the whole hearted support of that Association to the government for a defense program should the probability of a real M-Day become imminent. At the New York meeting of the American Medical Association, the House of Delegates in executive session commended the action of the Indiana State Association. This was the first State society to take such an action in the present emergency.

YOUNG DOCTORS WANTED BY THE ARMY

Several years ago we published in these columns excerpts from an article in the Military Surgeon by Captain Harry Armstrong in which the author accurately predicted the type of warfare now going on in Europe, warned against medical unpreparedness in our own country and outlined the ramifications of adequate medical military preparation here. He showed how a proper preparedness plan would integrate the Public Health Service, the State Health Departments, the medical schools, the medical societies and the individual doctor in a comprehensive scheme of coordinated effort. He estimated that it would require 47,000 doctors on active military service to meet the demands of two armies in the field. That is one-third of the entire medical profession in this country.

The present emergency is being met by the Surgeon General's office with appeals sent to medical societies as well as to doctors at large for physicians to join the Medical Reserve Corps of the Army. There is, apparently, no lack of doctors who would be interested in joining as majors and colonels, but applicants for the positions of first lieutenant are seemingly slow in presenting themselves. There are also movements on foot here and there designed to safeguard the interest of these doctors who enlist in the military service by protecting them against the loss of their patients while they are on active duty and by compensating them for financial loss during their absence. When one looks at the scale of pay the army is now, for example, offering to its lieutenants and captains in the Medical Corps, one is inclined to think that the majority of doctors who enter the military service will be better paid than they were before they left home. It is said that to equip an army in this country costs twenty times as much as to equip an army in Europe, and one can well understand that when one knows the schedule of pay now obtaining in all arms of the United States military service.

We are inclined to believe that a compulsory selective military training is the only fair and satisfactory solution of our military problem. Under its provisions the medical profession would naturally fall. Who should go and who should remain at home and under what conditions, would be more equitably decided under this plan than under any other and there would be less likelihood of unfairness to those who through patriotism are moved voluntarily to sacrifice economic security for God and country.

Edit., Va. Med. Monthly, Aug. 1940

——☆☆——

RATIO OF MARRIAGEABLE WOMEN AND MEN DISTURBED BY WAR

"One of the more serious effects of war is the depletion of young men and the disturbance of the ratios of marriageable males and females," *The Journal of the American Medical Association* for May 4 states. "In a recent brief review of this subject in the Statistical Bulletin of the Metropolitan Life Insurance Company it was pointed out that 72 per cent of German military deaths and approximately 55 per cent of the French losses in the last great war were of men under 30. This situation was reflected in the postwar ratios of the two sexes. The French census of 1911 showed substantially the same number of males as females in every five year age group; the 1921 census showed an excess of 261, 206 and 176 females per thousand males in the age groups 25 to 29, 30 to 34 and 35 to 39, respectively. In Germany likewise the prewar census of 1910 showed substantially equal proportions of males and females in each five year group. The 1925 census, however (the first taken by Germany after the war) showed an excess of 150 women per thousand men at ages 25 to 29, 259 per thousand at ages 30 to 34 and 181 per thousand at ages 35 to 39.

"Some of the results, such as the great increase in the proportion of marriages in the postwar period in which the groom was much older than the bride, were quite obvious. Another effect, although perhaps inextricably intertwined with economic factors, was the continued fall in the birth rate after the war. Clearly the actual battle losses are matched by losses in future population due to reductions in the birth rate. Futhermore, the relatively imponderable social effects of a deficiency of men, especially in certain age groups, must profoundly disturb the normal life of nations."

MEDICAL PROFESSION PREPARED FOR THE NEW CONSCRIPTION ACT

The medical profession is ready and willing to do its part in the efficient administration of the conscription act now before Congress, *The Journal of the American Medical Association* for Sept. 14 declares in an editorial which points out the great burden and responsibility the measure will place on the physicians of this country.

"The selective service act—usually called the conscription bill—has passed the House of Representatives and the Senate and now goes to the Conference Committee for final decision on certain differences," *The Journal* says. "No doubt by the end of the week this act will have been passed by both houses and will have been signed by the President. (This has now transpired—Ed.) Immediately, no doubt, in the individual states some thousands of draft boards or exemption boards will be established, with each of which there will be associated a physician. Physicians are already being asked in many states to volunteer for service with these boards. It has been suggested that they will be willing to contribute their services now as so many thousands of them did in 1917-1918. At that time arrangements were made to pay on a per diem basis for the services of physicians only in counties where physicians could not be found to contribute the services. We have no record of any such counties.

"The duty of the physician associated with the draft board is one of the utmost importance in relationship to securing a proper personnel for military service. On the physician rests the major part of the responsibility of deciding promptly whether claims for exemption on account of physical disability are just. Considering the fact that the physician associated with such a board is a resident in the district over which he has jurisdiction, the physician is not in an enviable position. He must hear the pleas not only of his friends and neighbors but also of his patients. To resist such importunities requires common honesty of purpose and a courage to do one's duty which is fundamental in the character of every good physician. No doubt he will be called on to detect malingering, perhaps to pass on certificates from family physicians and specialists certifying to disabilities which he will have to verify. The duties of physicians on these boards require not only honesty of purpose and courage to do right, even at the sacrifice of private practice, but also professional alertness to detect malingering and misrepresentation.

"It has been rather generally understood that the physicians on the draft boards will make only a preliminary survey of the candidates who come before them. Those selected will then be sent to special examining boards, which will be later constituted by the Army Medical Department. On these physical examining boards will rest the final decision as to whether or not the young man is to go to camp. These boards will be located in centers of population, preferably near military posts or stations, and will include eleven medical officers and one dental officer. More complete information relative to the establishment, perquisites and duties of these boards will be published later.

"In 1918, it will be remembered by many physicians, each draft board bore a relationship to a medical advisory board on which were placed the duties which now will be placed on the physical examining boards. It was found in 1918 that an average of 8.1 per cent of those examined were rejected for physical defects which were not picked up by the physical examiners of the local draft boards. This represented a total of 172,000 men between Feb. 10, 1916, and Oct. 31, 1918. These men were transported at government expense; in some instances they claimed aggravation of existing disabilities during travel from their homes to the military camps. The purpose of the new technic is to eliminate to a certain extent the number of men who are ordered into service and subsequently have to be rejected, and to eliminate as far as possible the responsibility of the government to individuals who will be without military value. Thus it is apparent that again a great burden and a great responsibility are to be placed on the physicians of our country.

"American physicians have never failed in the past to meet such a call. The members of the Committee on Medical Preparedness (of the American Medical Association), who have been authorized by the House of Delegates (of the Association) to cooperate with government officials in securing physicians for required services, have promised with confidence that the medical profession is ready and willing to do its part."

—☆☆—

DRAFT THE DOCTORS

The tragic state of unpreparedness that has spelled bitter defeat for the European democracies must not occur here. Medicine must do its part. In case of armed conflict, there will be broken bodies to mend, there will be last rites of mercy to perform. There must remain behind those to care for the civilian population. Wars usually bring epidemics—new problems to public health will arise. How well prepared is American medicine?

A number of the younger physicians proudly hold commissions in the reserves of the Army and the Navy. Patriotically they have worked at training problems, trying to better fit themselves for their posts. But so many are needed, and so few have responded. Plans to draft man power and industry and money should not omit the drafting of medicine. Every physician in this country should be drafted, assigned a post at home or in the field. The income of those left at home should be drastically controlled. Any excess over the scale paid the armed services should be pooled for the benefit of those who had to leave often good paying practices for the small remuneration of the armed services. If there should be no profiteering in industry, neither should there be in the professions! If the younger physicians are to offer their very lives as a pawn to destiny, let the older ones at home at least offer a portion of their monetary gains! Pretty speeches to the young man leaving a family behind, hoping to support them on the meagre salary of a junior officer, are simply not enough. That young man is no fool — he knows that a shattered practice, however good it may have been, will not feed his children. He will rightly resent any attempt on the part of those remaining behind to cash in on his withdrawal from the field. Young men who know they must go at the first call are demanding in growing strength of tone, that organized medicine work out and institute a plan fair to all. They say they only want an even break. The problem is squarely up to organized medicine. And, if our own bodies do not face it, study it, answer it correctly, depend on it that the government of the United States must and will answer it for us.

So, will the various societies of the American Medical Association draw plans of preparedness, or must they be forced to take something perhaps a lot less to their liking? Many others besides America's younger doctors are patiently waiting, waiting.

Edit.—Southwestern Med., July, 1940

—☆☆—

THE EVACUATION SCHEME OF CHILDREN IN ENGLAND

Commenting on whether or not the evacuation scheme of children has been successful as carried out in England, Doctor J. Ferguson in *Proceedings of the Royal Society of Medicine* (May, 1940) writes that is so far as the evacuation was intended to remove children from danger to safety, the answer is "No". An inadequate percentage of the population took advantage of the scheme in the first place, and of those who did very many returned — in Surrey 38% of school children and 54% of pre-school children and mothers. From the point of view of the householders the position as it is at present may be regarded as just tolerable, but certainly not welcome. The present hosts on the whole are doing their duty by their guests very well, and indeed very unselfishly. On all sides there is expert testimony to the marked improvement in the health and appearance of the evacuated children, and in the main to their improved conduct and discipline, the exception to the latter being the older children and adolescents. From the point of view of the receiving authorities their arrangements for dealing with the children in either physical or psychological departures from normal are fairly complete. In Surrey there are some 33 hostels, sick bays, or nurseries, established for the benefit of these children.

The Doctor's Office

Aaron Bobrow, M.D., announces the opening of an office for the General Practice of Medicine and Surgery, Standard Building, 242 Trumbull Street, Hartford.

-The- General Practitioner's Forum

For all around usefulness plaster of Paris has many advantages in the treatment of fractures. Properly applied, the plaster cast or splint fits the part more accurately, is more comfortable to wear and requires less attention than other forms of fixation. There is one other and subtle advantage, the neat, expertly done job is visual testimony to the attending physician's skill. The art of rolling plaster can be acquired at home, in spare moments and at little expense. Most department stores have slightly damaged or outworn clay and composition manikins used for display purposes. These usually can be had for the asking or, at most, for a nominal charge. Lifesize, they make excellent practice forms. Before using the model, give it a coat of clear lacquer followed by several well-rubbed coats of wax. This precaution and that of cutting the cast before it has thoroughly set will help preserve the model for many practice sessions. There are several points in the technique of applying plaster that should be mastered as they add up to greater comfort for the patient. Padding should not be too thick. It has a tendency to pack and will eventually result in a loose and uncomfortable cast. Bony prominences and the heels are usually protected with saddler's felt, but for some time now we have been using pieces of sponge rubber with complete satisfaction. The bandage itself should be applied evenly and snugly. When reversing is necessary always fold the bandage before it is applied to the cast. This minimizes the chances of forming lumps or creases. To keep within the ideal of a cast just thick enough to suit the need, each layer should be rubbed smooth. In a future column we hope to have pictures and a description of a gadget used for making molded plaster splints. The experimental model is in use now and is working out very well.

In *July* 26, 1940 *United States Public Health Reports*, Schwartz, Warren and Goldman describe a protective ointment for the prevention of poison ivy dermatitis. It is made up of 10% sodium perborate in a bland ointment base. Tests indicate that, applied to all parts subject to exposure, it protects the skin against massive doses of the toxin. It has one minor limitation, it must be freshly prepared to be most effective. One puzzling thing about poison ivy is the variability of the immunity to it. Time and again, patients with the dermatitis will state that despite many previous exposures, this one was the first to affect them. It would be interesting to get an explanation of that phenomenon, for it might go a long way toward explaining the whys of allergy.

A syringe with a frozen plunger is certainly no stranger in a doctor's office. Most attempts at separation end up in quick consignment of the broken pieces to the wastebasket. Either of the following procedures is recommended as being less hazardous both to your fingers and the syringe. Boil the syringe for five minutes. Remove and while it is still hot, spray the barrel with ethyl chloride and work the plunger. This will work in most cases. If that fails, place the syringe in the freezing tray of your refrigerator and leave it over night. If it isn't loose when you take it out, warm the barrel in the palm of your hand. This expands the barrel and because glass is not a good conductor of heat, the plunger remains contracted and is easily removed.

A clinical sign of value in the diagnosis of a retrocecal appendicitis is the so-called "prone-test". With the patient lying face down, palpation of the abdomen over the lower right quadrant will elicit a greatly increased tenderness.

T.R.P., M.D.

Our Neighbors

MASSACHUSETTS

On June 27, the Massachusetts Board of Registration in Medicine voted to limit the period for which an intern's license may be issued to three years. This is known as "limited registration" and permits interns or medical officers of hospitals to practice medicine only in the hospital or other institution designated in the special certificate or outside if under proper supervision by registered physicians. This law changes the one previously in effect by placing a definite time limit on these limited registrations.

* * * *

NEW HAMPSHIRE

At the annual meeting of the New Hampshire Medical Society held in May of this year, Doctor Ezra A. Jones was elected president and Doctor Charles H. Dolloff, vice-president for the coming year.

* * * *

NEW YORK

New York City has abandoned its former method of grading milk. On July 11, 1940, after considerable study by the New York City Health Department and its consultants and several months of hearings with producers, milk distributors, and representatives of the consuming public, the Board of Health adopted amendments to the City's Sanitary Code officially recognizing only one grade of milk, "Approved Milk." The standards defined for "Approved Milk" are better than those required formerly for Grade B and in some respects comparable to those required fromerly for Grade A. Certified milk will continue to be marketed as before but the total volume is so small that it is of little importance. The new law effects chiefly the economics of milk production and marketing and, it is hoped, will not discourage sanitary production.

The Nassau County Medical Society is conducting a series of Seminars in Obstetrics on the second Monday of each month in the Nassau Hospital Auditorium, Mineola, N.Y. The Seminars will be informal and practical and at each a different problem will be presented.

- NEWS -

from County Associations

Hartford

Doctor Welles A. Standish was recently made a Diplomate of the American Board of Surgery and Doctor Frank Stafford Jones of the American Board of Orthopedic Surgery.

Doctor D. Dillon Reidy has resumed practice after a very severe and unusual illness, a complication of acute appendicitis. His recovery is hailed by his colleagues as astounding and truly miraculous, a tribute to the efficacy of some of our most recently discovered drugs and methods of treatment.

Members of the County are again notified that the county member on the state-wide representative committee on Workmen's Compensation is Doctor George W. Dunn of 55 West Main Street, New Britain. Matters concerning this law and its working about which members might have problems or complaints, should be formally filed with him for the attention and action, if necessary, of the whole committee.

Many of our members took active part in the Clinical Congress held at New Haven, active not only in administrative and executive capacities but by presenting subjects and discussing papers rendering valuable contributions to the educational part of the program.

Vacations are over for most of us. Some there are who prefer autumn holidays from the routine of practice, but even these are generally back at their work by the time our combined educational and social gatherings are scheduled to begin. The first meeting of the Hartford Medical Society for the fall will be at the usual time, 8:30 p.m. on October 7. The speaker is to be Doctor Howard Mahorner, Assistant Professor of Surgery at Tulane University in New

LISTEN TO A FOETAL HEARTBEAT

— through the new "twin-channel" Davol Stethoscope Tube. This modern tube will improve your present stethoscope. Latex for long life, heavy wall for durability, and to exclude extraneous sounds, with length and weight just right to make it easy to carry and easy to use. One tube; twin channels. No obligation — want to try one? Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

Orleans, Louisiana. He will discuss varicose veins principally, and will consider other circulatory abnormalities of the extremities. He is a very active research worker and close associate of Doctor Alton Ochsner of the same University and his presentation should be well worth our while. The next meeting on October 21 will be one held jointly with the Hartford County Medical Society at the Bushnell Memorial building in Hartford and the speaker will be Doctor Joslin. Following these there will be men from various cities as our guests whom, we are sure, will receive the interest they and their contributions will merit.

The Hartford County Medical Association meeting is to be held in Manchester on Tuesday, October 22. Details will be found elsewhere in the *Journal.*

* * * *

Litchfield

On Thursday, September 12, President, Francis H. Griffiths, of the Charlotte Hungerford Hospital, and Mrs. Griffiths were hosts to the members of the Senior Staff and the Board of Governors at their home in Litchfield. Golf, deck tennis and other sports were enjoyed by the members during the afternoon. Following a delicious buffet supper, the group was entertained by Mr. Fred Curtiss Ells of Yokahama, Japan, an internationally known amateur photographer. Mr. Ells showed the life of a Korean farmer in a film which he made during a period of residence in Korea. He also showed films depicting the life cycle of the Preying Mantis.

The monthly tumor conference will be resumed at the Charlotte Hungerford Hospital this month. These meetings are held on the first Wednesday in each month at 11 a.m. in the Staff Conference Room. Any practicing physician is invited to attend.

Doctor and Mrs. Albert W. Buck, attended the meeting of the American Hospital Association in Boston from September 17 to 20. Doctor Buck is Chairman of Administrative Section I which presented a program on Wednesday, September 18.

The first fall meeting of the Torrington Medical Society was held at the Charlotte Hungerford Hospital on Wednesday evening, September 4. Doctor F. A. Sutherland showed pictures taken during his trip to Europe last year.

Doctor and Mrs. Robert Walker of Cornwall enjoyed a vacation during the latter part of September on Cape Cod.

During the past month Doctors Polito, Bienkowski and Hubert occupied new offices at 24 Church Street.

The annual meeting of the Board of Governors of the Charlotte Hungerford Hospital, at which will take place election of officers and appointment of staff members for the ensuing year, will be held on October 21st.

* * * *

New Haven

Doctor William F. Verdi of New Haven has received the Gold Medal Award of the New Haven Advertising Club this year for his outstanding contributions to the community.

At the annual Graduate Fortnight of the New York Academy of Medicine to be held in New York City, October 14-25, the following members of the New Haven County Medical Association will participate:—Robert M. Lewis, subject, Gonococcal Infections in the Female; John R. Paul, subject, Acute Poliomyelitis; George Blumer, subject, Rickettsial Diseases.

But certainly the high spot in the recent tohubohu here in New Haven was the feast of "wit and whittles" for past and present house officers of the New Haven Hospital on Tuesday evening, September 17. A venture which started innocently enough in 1932 when the hospital administration found itself in possession of an extra side of beef has become an institution. At the beginning one gussed that a chance to come back and break bread with one's fellows of the white-pants years would bring the boys out in droves. But it did—and it nearly wrecked the budget! Two years later word again went out that a meal "in the manner to which you are distinctly unaccustomed" was to be spread for the lads—and once more the lads came and devoured. Once more the grocers and butchers bought sables for their wives and big blue ribbons for their daughters.

Obviously this sort of thing could not go on indefinitely—or could it? But, anyway, "a friend of the hospital" (three guesses—you're right on the first one) dug down in his own pocket for the third fiesta. Now, really, here was the limit—nearly three hundred able bodied men, not to mention a dozen or more presumably able-bodied women, feasting and laughing and having a whale of a good time because a terrible nice anonymous gentleman thought they were good fellows and had probably worked hard and maybe hadn't been too well fed (who lost weight while on a house job? —who ever did?)

So it was decided about that time that "there ought to be some organization!" The idea was dropped promptly with the disbanding of the meeting and the Ways and Means Committee disintegrated into its component physicians.

But someone remembered—too late indeed to get word to the boys west of the Mississippi, but in time to summon three hundred civilized easterners to the party. Apertifs (or is it —tives) —well then, peanuts in the lounge preceded the usual amazing repast. Almost everybody paid their due tithe at the entrance door and no one wanted his money back. Even the cheese was authentic.

In due course the ringing of a water glass directed attention to the speaker's table where no one was surprised to see Doctor Max Taffel, alias Maxie the Boy Orator, on his feet already well launched into a stirring speech. Despite his protestations that all was in the democratic tradition, the company later agreed that none had ever witnessed a more finished piece of steam roller chicanery. In less than ten minutes Max had voted an elaborate organization into existence, had a constitution accepted, officers duly elected, and came critically near beguiling the members into voting to tax themselves Lord-knows-how-much. The day was saved by one of Max's elder teachers who managed to keep his head and propose that the matter of dues be left to the executive committee composed of Doctors Frederick N. Sperry, President, Samuel Harvey, Vice President, and John C. Mendillo, Secretary and Treasurer.

Doctor Sperry presently took the chair and with appropriate recollections of Doctor Dwight Fishwick's prowess as a Yale football end introduced him to talk informally about the mobile surgical unit in Finland of which he was chief. Doctor Fishwick, who returned to the United States within the month on the precarious voyage of the S. S. American Legion, recounted to a seriously attentive audience some of his experiences in the combat zone in Norway and the frustrated efforts of the unit to get to France. He expressed his admiration for the precision techniques of his fellow surgeons who in the exigencies of field surgery clung to the methods and habits ingrained in long years of strict training. "Even the incredible disipline of the German Army yielded to the insistence of our men." Doctor Fishwick ventured illuminating confidential opinions regarding the attitude of the people of conquered countries toward their German masters. Decrying the fact that he found himself helplessly talking with the tongue of a propagandist, the speaker, nevertheless, ended with a straight forward appeal for prompt and active alliance of our country with Great Britain. His words carried the conviction of a man of action fresh from the field of it.

Doctor James Fox next spoke briefly about the proposed Yale Base Hospital, describing the probable organization and facilities of the unit and expressing the hope that the authorities of the Federal Government will shortly perform the official miracle that transforms a plan into reality. Doctor Fox modestly intimated that the men of the professional staff in the unit would probably not be found wanting in attention to duty.

President Sperry '94-'95 espied two fellow house officers who served as he did in an earlier century, Doctor Louis E. Cooper of New Haven '86-'87 and Doctor Frank Lawton of Hartford '93-'94, and forthwith hailed them to their feet. They recalled episodes of the "old days" and graciously welcomed the fellowship of their legion successors. The meeting ended with a delicate anecdote by the President relating the circumstances of the first pair of rubber gloves ever worn in the New Haven Hospital!

It would seem quite unnecessary to record that the affair had just the proper mixture of gayety, sentiment and unceremonial seriousness to make the first official meeting of the Association of House Officers of the New Haven Hospital a memorable event.

SPECIAL NOTICES

PROGRAM

for the meeting of the Association of Connecticut Tumor Clinics to be held at the Bridgeport Hospital on Thursday, October 17, 1940 at 4:00 P.M.

Chairman — Dr. D. C. Patterson

Benign Tumors of the Breast A statistical study	Dr. John F. Nolan
Pathology of Benign Tumors of the Breast	Dr. W. T. Clark
Carcinoma of the Breast A statistical study	Dr. W. A. Geer
Simple Mastectomy A discussion	Dr. John O'Connell
Radical Mastectomy A discussion	Dr. John Shea
Irradiation Therapy for Cancer of the Breast	Dr. B. M. Parmelee
The Treatment of Local Recurrences and Metastases	Dr. W. L. Weadon

Dinner will be served at about 6:00 P.M.at the hospital.

* * * *

INTERNATIONAL MEDICAL ASSEMBLY

The 25th International Medical Assembly of the Interstate Post-graduate Medical Association of North America will meet this year in the Cleveland Public Auditorium, Cleveland, Ohio, on October 14-18. There will be pre- and post-assembly clinics in the Cleveland hospitals on the two Saturdays before and after the Assembly. The list of speakers includes outstanding physicians and surgeons from all over the United States. From Connecticut we note Doctor John P. Peters, New Haven, on "Some Observations in the Nature of Acute Nephritis."

All physicians, members of their County and State organizations and in good standing, are invited to register by paying the usual fee of five dollars ($5.00). Airline rates to and from Cleveland have been reduced. A large and most comprehensive scientific and technical exhibit will be shown at the Assembly.

* * * *

1940 GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

The 1940 Graduate Fortnight of the New York Academy of Medicine will be held from October 14 to 25. The subject of this Fortnight will be Infections. Morning panel discussions, afternoon hospital clinics, evening addresses, scientific exhibits and demonstrations make up the complete program. The registration fee is $5.00 and should be sent to Doctor Mahlon Ashford, New York Academy of Medicine, 2 East 103 Street, New York, N.Y.

SCHEDULE OF MEDICAL CLINICS — HARTFORD HOSPITAL

October 1940.

1st — Significance of Certain Laboratory Procedures
8th — Clinical Pathological Conference
15th — The Irritable Colon and Constipation
22nd — Ward Case Presentations
29th — Open date

November 1940.

5th — Common Eye Conditions
12th — Clinical Pathological Conference
19th — Tuberculosis
26th — Ward Case Presentation

December 1940.

3rd — Thyroid Disease
10th — Clinical Pathological Conference
17th — Obesity and Undernutrition

January 1941.

7th — Common Skin Diseases
14th — Clinical Pathological Conference
21st — Urinary Tract Infections in Children
28th — Ward Case Presentations

February 1941.

4th — Endocrinology
11th — Clinical Pathological Conference
18th — Treatment of Syphilis
25th — Ward Case Presentations

March 1941.

4th — Common Lesions of the Rectum and Anus
11th — Clinical Pathological Conference
18th — Common Genito-Urinary Conditions — Dr. Glass
25th — Ward Case Presentations

April 1941.

1st — Arthritis
8th — Clinical Pathological Conference
15th — Lung Abscess and Bronchiectasis
22nd — Ward Case Presentations
29th — Open date.

* * * *

ANNUAL MEETING OF CONNECTICUT TUBERCULOSIS ASSOCIATION

The first annual meeting of the Connecticut Tuberculosis Association will be held in Hartford on Wednesday, October 23, at the City Club, 10 Allyn Street. Dinner—6:30 P.M. Reports on the development of the program of the new State Association and election of additional Representative Directors and Directors-at-Large will be made to complete the organization.

Mrs. Sadie Orr Dunbar, one of the outstanding tuberculosis workers in the country, and also President of the General Federation of Women's Clubs, Washington, D. C., will be the principal speaker.

Dr. David R. Lyman, President of the State Association will preside, and other speakers will include representatives from other associations in New England and in New York City.

• OBITUARY •

HANS ZINSSER
1878-1940

Doctor Hans Zinsser died of leukemia at the Memorial Hospital in New York on September 4 at the age of 61. Although he knew for two years that he was suffering from an incurable disease, he never faltered in his gallant course. On the contrary, he pushed forward his investigations, taught with characteristic enthusiasm, and published "As I Remember Him", his deeply-moving, delightful, philosophical autobiography. In his death, science, medical education, and the profession he honored lost a brilliant and productive servant. His many friends who were attached to him with intense loyalty have lost a charming and beloved companion. They and all who knew him throughout the world will remember him as a creative leader who even in the way he met death contributed to the nobility of human life.

Hans Zinsser was born in New York City on November 17, 1878. His parents were Germans "who came to America because they loved the things America stood for." He grew up in surroundings of liberalism, intellectual vigor, devotion to truth, and participant appreciation of art, music, and literature.

After graduating from Columbia with the B.A. degree in 1899 he gained the M.D. at the College of Physicians and Surgeons in 1903. He served in various positions in hospitals and started to practice medicine. Attracted more strongly by research and teaching in bacteriology and immunology he gave up practice and entered the laboratory. By 1911 he was Professor of Bacteriology at Stanford University in California. In 1913 he returned to Columbia as Professor of Bacteriology and in 1923 he went to the Harvard Medical School as Professor of Bacteriology and Immunology. He held this position until his death.

Through his researches Doctor Zinsser contributed new knowledge to many fields. The most original and important were his studies of the chemistry and mechanism of the tuberculin reaction, the discovery of the specific soluble substance (later identified as polysaccharide) of streptococci and pneumococci, and finally his extensive work on typhus fever and the pestilences caused by various kinds of *Rickettsia*. He helped to differentiate the European and American forms of typhus fever. With great skill, persistence and at the risk of his life he devised methods of cultivating the parasite causing typhus, prepared a preventive vaccine and a serum to be used in treatment. Since 1939 he was actively engaged in making the materials and methods found effective in the laboratory available on a large scale for the prevention and treatment of typhus in human beings.

In 1934, in the course of his risky, exciting and exhausting fight against typhus fever, it "amused and rested" Doctor Zinsser to write "Rats, Lice and History" — another best-seller, in which he combined whimsicality with profound thought. He was impressed with the importance of the influence of calamitous infectious diseases, of which typhus is a prime example, upon the fate of nations and "indeed upon the rise and fall of civilizations." His studies and general comprehension took in all parts of an intricate problem. A quotation of his own words may be used to put a value on his work. "Typhus is not dead. But its freedom of action is being restricted, and more and more it will be confined, like other savage creatures, in the zoological gardens of controlled diseases."

For his service in the first world war he was decorated with the Distinguished Service Medal and the Legion d'Honneur. Entering the U.S. Army Medical Corps as a Major he was soon promoted to Colonel, and served, among other commissions, as Sanitary Inspector of the First Army Corps and of the Second Army of the A.E.F. in France. During the war he was assistant director of laboratories and one of the chief epidemiologists in charge of control of infectious diseases.

In 1915 Doctor Zinsser went to Serbia as a member of the Red Cross Commission to combat typhus fever. In 1923 he worked in Russia as sanitary commissioner of the League of Nations.

Doctor Zinsser was honored by election to membership and high office in many scientific societies in this country and abroad. He was a member of the National Academy of Science. The honorary degree of Doctor of Science was conferred upon him by Columbia, Northwestern, Lehigh, Yale and Harvard.

In 1935 he was exchange professor at the University of Paris and in 1938 he was a visiting professor at Peiping Union Medical College. His personal teaching, like his textbooks of bacteriology and immunology, was in these ways brought to students both in this country and abroad. These and other events of his last years gave scope to his public service as a citizen of the world and were evidence of the world-wide esteem in which he was held.

S. Bayne-Jones, M.D.

• Quarto Notes •

DIAGNOSIS AND TREATMENT OF PULMONARY TUBERCULOSIS

by

John B. Hawes, 2nd, M.D. and Moses J. Stone, M.D.

Second Edition. Revised by Dr. Moses J. Stone

260 pages

Philadelphia Lea & Febiger 1940

This book very capably fills the need for a physician's text book on tuberculosis. Although the treatment of this disease is usually left to the specialist, the diagnosis is the problem of the practitioner. Perusal of this book would assist many in locating the early case.

It is both comprehensive and brief and confines itself to generally accepted knowledge and to fact. It is easily read and adequately illustrated.

In discussion of symptoms and signs and in differential diagnosis, the manifestations of the disease are divided into local and constitutional. This is of special value in differential diagnosis.

A new chapter, not in the first edition, is the one on allergy and immunity. This complicated subject has been made to appear simple and lucid.

When treatment is considered, the indications for the various types of collapse therapy are mentioned. When such is not indicated and when sanatorium care is not feasible, home treatment is discussed.

Doctor Stone is to be congratulated for revising this volume and supplying the medical profession with a valuable text.

J. L. Cogland

SEX AND LIFE

Forty Years of Biological and Medical Experiments

by

Eugene Steinach, M.D., Ph. D.,

Formerly Professor of Physiology at the University of Vienna

The Scientific Values Adapted to the Lay Reader by Josef Loebel, M.D.

252 pages 67 illustrations $3.75

New York The Viking Press 1940

This book is a popular science exposition of the physiological experimentation of its author, extending over a period of nearly fifty years and comprising the major portion of his life work. Its thesis is that the development and regression of the life of the individual is a function of his endocrinological apparatus, and primarily of the internal secretary part of his gonads. This thesis is logically developed by a chronological sequence of experiments, starting with extirpation and transplantation of the gonads in rats and guinea pigs, progressing through the proof of the importance of the interstitial cells, and culminating in a promotional exposition of the "Steinach operation" — vasectomy or "vasoligature." The purpose of this operation, which has been promoted by Steinach and his disciples for many years, is an induced hypertrophy of the testicular interstitial cells of Leydig, consequent upon the atrophy of germinal elements which follows vasectomy. It is conceded that the development of injectable sex hormones has in recent years rendered the actual surgical procedure unnecessary, and the benefits of the Steinach operation are now available by administration of the hormone.

It is emphasized that these benefits extend far beyond the more or less incidental enhancement of sexual potency and libido in the aging organism. Indeed they involve attack on the fundamental cause of the aging process itself, that is, on the diminished tissue blood supply of senility. The latter is held to be responsible for the concentration, dehydration and contraction of cells and tissues throughout the body, which is the essence of senility. The author does not hesitate to claim the most specific and far-reaching results for his treatment, for example, in hypertension and angina pectoris. "The traditional modes of combating senility by attacking its individual symptoms, such as cataract, arteriosclerosis, and heart disease, are now altogether antiquated." (p. 11)

Such far-reaching claims, and the promotional character of their presentation, constitute the book's chief faults, all the more serious because it is designed to appeal to the layman. Noteworthy also is the fact that of all the articles in the Bibliography, some fifty in number, Steinach himself is the author, or co-author.

On the other hand the experimental method as applied to problems in physiology is well expounded and illustrated for the layman, and a generally satisfactory picture of our knowledge of sex endocrinology is presented.

H. S. Warren

GYNECOLOGICAL AND OBSTETRICAL PATHOLOGY WITH CLINICAL AND ENDOCRINE RELATIONS

by

Emil Novak, A.B. M.D., D. Sc. (Hon. Dublin) F.A.C.S.
Associate in Gynecology, The Johns Hopkins Medical School

496 pages 427 illustrations $7.50
Philadelphia W. B. Saunders Co. 1940

This is an excellent book written by one of the leading gynecologists of the present day and presented in the clear thorough manner which is so characteristic of this great teacher of gynecology and gynecological pathology. The author gives his own opinions on controversial points, discusses the opinions of other leading authorities in the field and makes clear his reasons for disagreeing. This feature of the book is extremely valuable where knowledge of the hormones in particular is increasing so rapidly.

As stated by Doctor Novak in the preface, the book "represents his own concept of the composite needs of the student, practitioner, specialist and pathologist in this particular field." The number of illustrations, chiefly of microscopical pathology, very nearly equals the number of pages in the volume and adds tremendously to its value.

As in most volumes of its kind the diseases of the vulva, vagina, cervix, uterus, tubes and ovaries are dealt with separately. In addition, several chapters are devoted to different conditions found in the endometrium, and the various ovarian tumors are classified and presented in considerable detail. The author has contributed much in the field of ovarian tumors so that his discussion of the same carries particular weight. There is an excellent chapter on the elements of reproductive endocrinology and another (contributed by Doctor Louis M. Hellman) on Diseases of the Placenta other than Hydatidiform Mole and Chorionepethelioma. A careful perusal of this book impresses me as being by far one of the most valuable of its kind published. To add to its usefulness, there is found at the end of each chapter a short list of references which include the more worthwhile publications on the particular topic.

* * * *

FRANK HOWARD LAHEY BIRTHDAY VOLUME — JUNE FIRST NINETEEN HUNDRED FORTY

466 pages
Springfield, Illinois Charles C. Thomas 1940

Frank Howard Lahey, so recently elected President of the American Medical Association, has a host of friends. Many of his friends, both lay and medical, published this birthday volume in his honor and prefaced the volume with a most fitting dedication.

The book contains scientific papers by fifty-four authors from various parts of the United States and Canada, some of them surgeons, some of them internists. Connecticut is represented by Daniel C. Patterson with a paper on "The Use of Sclerosing Solutions in the Repair of Dehiscent Wounds." The majority of the discussions are on subjects related to the gastrointestinal tract, many deal with the thyroid gland.

The essay on "Group Medicine and the Lahey Clinic" discusses the secret of a successful form of group practice as found in that clinic. The chapter near the close of the volume, entitled "Mental Laundries," by Ray Lyman Wilbur, is well worth reading — and remembering.

As the *Journal of the American Medical Association* has remarked, "the volume is in its appearance and in its contents distinctive among publications of this type". The illustrations are excellent, the printing is neatly and well done, the whole appearance is attractive. It is a fitting tribute to so able a surgeon on his sixtieth birthday.

* * * *

NEOPLASTIC DISEASES

by

James Ewing, A.M., M.D., Sc.D., LL.D. Professor of Oncology, Cornell University Medical College, New York City

1160 pages 581 illustrations—Fourth Edition $14.00
Philadelphia W. B. Saunders Co. 1940

In the fourth edition of "Neoplastic Diseases" Dr. James Ewing presents once again a most complete and comprehensive book on cancer pathology. In this edition there are a few additions and changes from the third edition, published twelve years ago. The subject of trauma and its etiological relationship to cancer is more thoroughly discussed; and, in general, the author believes that trauma and cancer have much more of a coincidental than associated relationship. In many chapters Dr. Ewing has added paragraphs on therapy with end results as quoted from authoritative sources.

The chapter on cysts and epithelial tumors of the ovary has been completely rewritten with the addition of a discussion and microphotographs of the more recently clarified ovarian tumors, such as: Brenner, granulosa cell, arrhenoblastoma, theca-cell, luteoma, and disgerminoma. Throughout the volume are also descriptions of other new tumors which have been identified since the last edition; examples of these include such tumors as: glomus, tumors of the islands of Langerhans, and basophilic adenoma of the pituitary.

In other words, Dr. Ewing has brought up to date in this fourth edition the finest complete compendium of neoplastic diseases. The style is clear and easy to read, the selection and reproduction of photographs and microphotographs are excellent, and the bibliography and index are complete in every detail. This book should be in every doctor's library.

S. S. Quarrier

* * * *

SOCIAL SECURITY IN THE UNITED STATES 1940

A Record of the Thirteenth National Conference on Social Security

174 pages $2.00
New York American Association for Social Security 1940

Whether or not one agrees with much or little that is printed between the covers of this book it is interesting reading. With the pending legislation on health insurance, the housing plans cropping up all over the country, and the dissatisfaction with the workmen's compensation laws as they now exist, Mr. Average Citizen and Doctor So-and-so will do well to learn both sides of the story.

The Conference reviewed in this volume brought out many of the limitations and faults in our present social security laws. The remedies offered are those of a particular group of social workers, advocates of broad, wholesale social legislation, radicals, if you will, but still representing a class of American people who must be heard.

The reviewer attended that part of the Conference dealing with health insurance. Some of the speakers were good, some were bigoted and heaped only calumny on the medical profession. One of the most enlightening and interesting was the representative of organized labor whose address appeared in an earlier issue of this *Journal* (vol. iv. No. 6, June 1940).

Out of all this discussion must come something of value because we are passing through a period of social evolution as well as revolution and the Social Security proponents are serious in their efforts.

* * * *

A MANUAL OF THE COMMON CONTAGIOUS DISEASES

by

Philip Moen Stimson, A.B. M.D. Assistant Professor of Clinical Pediatrics, Cornell Medical College; Visiting Physician, Willard Parker Hospital; Chief of Staff, The Floating Hospital of St. John's Guild; Associate Attending Pediatrician, The New York Hospital; Diplomate, American Board Pediatrics; Fellow American Academy Pediatrics

463 pages Third Edition, Thoroughly Revised $2.50
Illustrated with 54 engravings and 6 plates, 4 in color
Philadelphia Lea and Febiger 1940

This book embodies fifteen (15) chapters in all. In order of their appearance the chapters include Principles of Contagion; Serum Reactions; Diphtheria; Vincent's Angina; Scarlet Fever; Measles; Rubella; Whooping Cough; Mumps; Chicken Pox; Meningococcic Meningitis; Poliomyelitis and The General Management of Contagious Diseases.

The publication is meritorious in its entirety. It represents the toil of many hours directed toward the summarization of the medical knowledge upon these subjects. However, as is common to all manuals which are really compendiums, while the essential subject matter prevails throughout, there are occasional valuable points not mentioned because of lack of space and the usual fatigue which authors suffer after perusing voluminous medical papers.

The work is adequate, concise, instructive and substantial. It is a distinctive manual dealing with contagious diseases for physicians and advanced nurses.

C. L. Thenebe

For Non-Professional Visiting Hours

When the visitors are friends, introduce the Scotch that wins a warm reception—mellow Johnnie Walker.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE
Wyeth
is indicated in the treatment of

★ Acute Anterior Urethritis (due to Neisseria gonorrheae)
★ Trichomonas Vaginalis Vaginitis
★ Vaginal Moniliasis
★ Bartholinitis and Skeneitis (due to Trichomonas Vaginalis)

Silver Picrate is a definite crystalline compound of silver and picric acid. Available in the form of crystals and soluble trituration for the preparation of solutions; suppositories; water-soluble jelly; and powder for insufflation.

Complete information mailed on request

★ JOHN WYETH & BROTHER, INCORPORATED ★
PHILADELPHIA, PA.

GETTING READY TO BE A MOTHER

by
Carolyn Conant Van Blarcom
Revised by Hazel Corbin,
General Maternity Center Association

190 pages Fourth edition $2.50
New York The Macmillan Co. 1940

To those who are familiar with previous editions of this book little need be said except to call attention to the new illustrations which make this edition even more valuable. Unfortunately many young mothers approach pregnancy today entirely ignorant of many of the fundamental facts, a knowledge of which will aid greatly to peace of mind, as well as assist in a healthier happier antepartum period and in a more intelligent care of the new born baby.

How should an obstetrician be chosen? How pick your hospital? What should the baby wear in its first few weeks of existence? What is a normal daily program for the pregnant woman and, later, for both mother and baby? All these and many more questions are answered in this volume. The development of the baby from the start is well illustrated and enough of the physiology of labor is portrayed so that the reader may have a reasonable conception of what it is all about.

This is the kind of a book that should find its way into the hands of every expectant mother. It makes an ideal gift to the pregnant woman because of its clarity and common sense and should dispel much of the nebulousness enshrouding pregnancy.

STATE CONFERENCE—HIGHWAY ACCIDENTS

(*Continued from Page 612*)

Major Vernon Morehouse, Highway Safety Commission

E. Kent Hubbard, President, Connecticut Manufacturers Association

Winthrop H. Whitney, President, Connecticut Chamber of Commerce

Arthur B. Landry, President, Connecticut State Medical Society

Creighton Barker, Secretary, Connecticut State Medical Society

Allerton F. Brooks, Vice-President, Southern New England Telephone Co.

Robert M. Yergason, Connecticut State Medical Society

Edward H. Crosby, Connecticut State Medical Society

John J. Snavely, Safety Department, N.Y. N.H. & Hartford Railroad.

Albert T. Pierson, Special Representative N. Y., N. H. & Hartford Railroad.

Samuel Driver, General Agent of the Railway Express Agency

Lieutenant Ralph Buckley, State Police

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN:

Connecticut State Medical Society (1940-1941) . . . 4
Connecticut Hospital Association (1939-1940) . . . 5

ORIGINAL PAPERS:

Beginnings of Medical Practice in New Haven Colony — Herbert Thoms, M.D., New Haven, Conn. 639
Emergency Treatment of Fractures . . . Clay Ray Murray, M.D., New York, N.Y. 645
Results of Four Types of Therapy in 165 Cases of Pneumonia — Peter J. Steincrohn, M.D., Hartford, Conn. 653
Fundamental Principles of Treatment of Gonococcal Infections of Women — Robert M. Lewis, M.D., New Haven, Conn. 662
Problems Relating to Diphtheria Toxoid Immunization M. M. Hillman, M.D., New Haven, Conn. 664
Treatment of Compound Fractures . . Daniel C. Patterson, M.D., Bridgeport, Conn. 666
Tumors of Lateral Aberrant Thyroid Tissue — Report of Two Cases — William A. Geer, M.D., Bridgeport, Conn. 670

STATE DEPARTMENT OF HEALTH:

What the Family Physician May Expect from the Public Health Nurse — Hazel V. Dudley, R.N., Hartford, Conn. 672

EDITORIALS:

Stop and Think . . . 674
Who Hath Desired the Sea? . . . 674
The Use of Tobacco . . . 675
Periodic Health Examinations in the Prevention of Cancer . . . 676
The State of Our Health . . . 676
Doctor Alexander S. Begg . . . 677
Birthday . . . 677
CLINICAL CONGRESS — 1940 — RETROSPECT — M. J. Strauss, M.D., New Haven, Conn. 678
FROM THE SECRETARY'S OFFICE . . . 679
CONNECTICUT HOSPITAL ASSOCIATION . . . 682
AMERICAN RED CROSS . . . 690
THE GENERAL PRACTITIONER'S FORUM . . . 691
OUR NEIGHBORS . . . 692
NEWS FROM COUNTY ASSOCIATIONS . . . 692
NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE . . . 669
THE DOCTOR'S OFFICE . . . 669
SPECIAL NOTICES . . . 697

OBITUARIES:

Harry Burr Ferris, M.D. . . . Creighton Barker, M.D. 699
Daniel Andrew Nolan, M.D. . . . James Murphy, M.D. 700
QUARTO NOTES (Book Reviews) . . . 701

ABSTRACT:

Method of Nutritional Protection During Senescence . . . 706

Clinical Research

The practice of medicine takes on fresh appeal as more and more medicinal agents of proved therapeutic value become available. The Lilly Research Laboratories constantly co-operate with a large number of clinicians in the investigation of new substances for treatment of disease.

Liver Extracts, Lilly
For Parenteral Use

Names revised to indicate potency in U.S.P. units.

Ampoules Solution Liver Extract, Lilly,
1 U.S.P. unit per cc.

Ampoules Solution Liver Extract, Lilly,
2 U.S.P. units per cc.

Ampoules Solution Liver Extract, Lilly,
15 U.S.P. units per cc.

ELI LILLY AND COMPANY

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

The Connecticut State Medical Journal

Vol. IV. NOVEMBER, 1940 No. 11

The Beginnings of Medical Practice* in New Haven Colony

HERBERT THOMS, M.D.,
New Haven, Conn.

The Sesquicentennial of the Connecticut State Medical Society will be celebrated at Middletown in 1942. In anticipation of that event the *Journal* will publish a series of historical papers on different phases of medical history in the eight counties of Connecticut. The following from the pen of Doctor Thoms is the first of this series. [*The Editor.*]

From the standpoint of present day medical knowledge the story of medicine in the early colonial period is not an attractive one. For the greater part the ridiculous treatment and the absurd remedies accorded the sick in that day were valueless. Nevertheless, the meagre accounts that tell us of the medical life of that period are inspiring, and one reads of the endeavors and contentions of these earnest medical pioneers with sincere admiration.

The colony of New Haven from its inception was a compact, thriving community. It comprised among its inhabitants people who were wealthy and educated. Although Bacon in Atwater's History says that "New Haven Colony managed to be born and pass some years of its life without the help of any doctor of its own," it is reasonable to believe that Mr. Thomas Pell acted in this capacity almost from the first. Bolton, in his History of Westchester County, says that Pell was a resident in Fairfield in 1635 and in New Haven in 1642. We do find that he appears in the Records as an attorney for the executor of Richard Jewellin, September 6th, 1642. The first reference to his medical life appears December 3rd, 1645, in connection with a gunshot wound. Because of "the great damage Stephen Madcalfe had susteyned in the losse of his eye, with the losse of his time & the great chardge of the cure, Mr. Pell affirming it was worth 10 L" the court "ordered Francis Linley to pay to Stephen Medcalfe 20L damadges."

Pell, who was born and educated an English gentleman, would have been immediately attracted to the new Colony, which numbered among its people so many men of his own intellectual sphere. His father, the Rev. John Pell, of Southwyke in Sussex, died in 1616, leaving two sons, the Rev. John Pell, D.D., rector of Fobbing in Essex, afterward ambassador to the Swiss Cantons, and Thomas Pell described as gentleman "to the bedchamber" to King Charles I and first Lord and proprietor of the manor of Pelham. He was born about 1608 and although his exact arrival in America is unknown, he was one of New England's first settlers. His name is associated with Roger Ludlow of the Rev. John Warhams Company at Dorchester, Mass., in June, 1630. In 1636 he acted as Surgeon to the Saybrook Fort and in the next year accompanied Captain Underhill to the Pequot war.

Pell came to New Haven shortly after its settlement and on the tenth of March, 1646, we find it recorded that he was an occupant of the first seat on the cross benches at the end of the Meeting House with Mr. Tutle and Bro. Fowler. In 1646-47 he married the widow of Francis Brewster (Lucy) of New Haven and this act, together with his service in the risky Pequot war, assures us, says Dr. Francis Bacon, that his intrepidity is undoubted.

---

*Reprinted in part from the Yale Journal of Biology and Medicine.

Both Thomas Pell and his wife appear somewhat prominently in the early Records, the latter in a trial for slander which occupies some eighteen pages of the transactions and the former because of his persistent refusal to pay a debt of 200L which his wife contracted before their marriage. That he was a man of enterprise is unquestioned and he not only practised medicine but we find that he engaged in various commercial pursuits. In 1647 he traded to the Delaware and Virginia. As there were no professional lawyers in the colony Mr. Pell not infrequently acted in this capacity for others. Pell was a man of independence and spirit and at least one man in the Colony was not particularly awed by the Court proceedings.

If Thomas Pell was as skillful a physician as he appears to have been a lawyer, the health of New Haven Colony was in safe hands. In 1654 he removed to Westchester County, New York, and became proprietor of Lands, now known as Pelham Manor. He died in 1669 of what was called Hasty Consumption and was buried at Fairfield. His estate shows him to have been a man of considerable wealth.

Nicholas Augur is the second physician who appears in the Records in 1643 as grantee of a lot "reserved for an elder" at the corner now occupied by the Colonial Building at Church and Elm Street. There are reasons to believe that Augur practised medicine more assiduously than Pell, because his name appears after this date frequently in connection with medical matters although he, too, traded with the other colonies, it appears his main dependence was in medical practice. Nicholas Augur seems to have had a rather discouraging time, and his experiences as witnessed by the Court Records together with his untimely death, give a melancholic aspect to his career. His chief difficulty in practice seems to have been in obtaining remuneration for his services.

Patients in that day apparently were no more prompt in the settlement of their accounts than some of their descendants, for in February 4, 1650, Mr. Augur acquainted the Court that he had given "Phisicke to Mr. Malbon's servants, namely Captive and Francis Bradshaw, and something to a mare that was bitten with a rattlesnake and that there is due him for it 44S 10d. he desires the court would afford him some help that he might be paid" and in February, 1658, "the Gov. declared that Mr. Augur had been with him and informed him of his intentions to lay down the practice of physic because his pay is not brot in in season for what he hath done, which was witnessed against as an act of unrighteousness; those which were faulty herein were desired to attend their duty that these discouragements may be removed from Mr. Augur." Again a year later, in January, 1659, he says, "his stock of physic is gone and how to procure more out of his returne he saw not, being disabled by the non-payment of some and the unsuitable payment of others to get supplies."

Mr. Augur was also to suffer from further competition for as soon as it was learned that Mr. Pell was going away,

> "The Gov. informed the Court (June 17, 1650) that Mr. Crane had given him notice of a 'surgeon or Phisition' that was lately passed thro the town towards the Dutch, that he heard had lived some considerable time in Plymouth, Pattent, and he had been of good use there as appears by sundry testimonies he had to show, under the hands of divers of that Jurisdiction; and seeing Mr. Pell is now going away, whether it may not be good for this town to use some means that he might be staid here, and that himself had written to Capt. Astwood that if he was yet at Milford he might be desired to stay, that we might further consider about it; and accordingly the thing is done, and the man is come back now therefore the Court may consider what they will do; the Court liked well of what was done, and by vote declared that they desired he should stay here; "and desired and appointed the magistrates and deputies to treat with him and take such order for his staying here as they think may be for the good of the town."

This man was Mr. Besthup and he appears to have remained for a short time at least; seven days later we read that

> "Wash and Indian complained of a seaman which went in Michaell Taynters vessel that he hath broke his arm and upon examination and the judgment of Mr. Augur

> and Mr. Besthup found it to be so, the said Wash refusing any satisfaction but healing — and Mr. Besthup took the Indian in hand to cure and by Gods blessing effected it."

Mr. Besthup, however, appears no more and we surmise that he decided to continue his journey "toward the Dutch." Governor Eaton appears to have been on the lookout for another practitioner for on November 14, 1651, a Doctor Chayes or Chais came to the Colony. He appears to have practised in New Haven for a time but he was quite dissatisfied with his success, and did not stay long and Augur remained. The latter was possibly an unsatisfactory doctor from the Governor's standpoint, but we believe he was at least dependable. Before proceeding with other practitioners it will interest us to consider the tragic ending of the career of Nicholas Augur. This incident is depicted in the Magnalia of Cotton Mather and it will be interesting to let that unique literary artist tell us the story.

"On August 25, 1676, Mr. Ephriam Howe, with his two sons (and Mr. Augur), did set sail from New Haven for Boston, in a small ketch of about 17 tun. On his return-winds-and weather became so tempestuous that it forced them off to sea where the outrageous winds and seas did often almost overwhelm them and here in about 11 days the elder son died and in a few days more the younger — their straits and fears were now increased as their hands diminished and another of the "company soon after died like the former. Half the company was now gone; and Mr. Howe, though in a very weak state of health, now stands at the helm twenty-four hours and thirty-six hours at a time, with the rude waves flying over the vessel at such a rate that if he had not been lashed fast he must have washed overboard."

After a month out their rudder became lost and eventually they came on a desolate island (near Cape Sable) "which had not either man or beast on it, and a prospect of being therefore starved quickly to death now stared upon them." Later their vessel was stove to pieces and "a cask of powder was brought ashoar, a barrel of wine and half a barrel of mollossa's." After twelve weeks of starvation, exposure and sickness we are told Mr. Augur died and the lad in the following April, then for three months more Mr. Howe subsisted as best as he could on this wretched island and finally attracted a passing vessel which took him into Salem July 8, 1677. In the will of Nicholas Augur are mentioned his Sister, Esther Coster, and his brothers John and Robert, and Nicholas, the son of John, and the youngest of John's sons. What property he possessed was left chiefly to his sister. The medical portion of his legacy she subsequently sold to the town of Guilford. On July 3, 1679, a town meeting was held in that place "to consider whether the inhabitants would buy Mrs. Coster's Physic and Physical drugs, and it was answered by a unanimous vote that they would buy them" and subsequently, August 28, 1679**"Lieut. Wm. Seward was chosen and appointed to fetch or procure the Phesseck and Pheseckall drugs bought of Mrs. Cosster, brought to Guilford and deliver them into the hands of Mr. Joseph Elliott for the town's use." This Mr. Elliott was the Rev. Joseph Eliot, the father of the Rev. Jared Eliot, who practised as did his son later what Cotton Mather called the "angelic conjunction of Skill in Physic and the Study of Divinity." Thus did Nicholas Augur become, in a measure, a medical ancestor of the man who a generation later was to become so eminent as a Divine as a Botanist, and as the first Physician of his time throughout Connecticut.

In spite of the unsuccessful efforts to interest the itinerants Besthup and Chais, the Colony apparently was not discouraged. In 1654 the governor was desired to write to John Winthrop, Jr. of New London and invite him "to come and live at New Haven, if he doe remove from Pequott." The next year Winthrop arrived and New Haven may indeed be proud to number among her first citizens the scholar, the physician, and the distinguished magistrate that were embodied in John Winthrop, Jr.

As a scientist and a physician he was well known throughout the New England Colonies and Bacon says that "from his education and from his pursuits he was more familiar with the chemistry of that day than any other man on this side of the ocean." Winthrop came to this country in 1631 at the completion of an ex-extensive college education, joining his father, Governor John Winthrop of Massachusetts. After some traveling which included two trips to England, he settled in New London where he lived for eight years, removing to New Haven in 1655. Although much given to scientific pursuits because of the "scarcity of physicians in the Colonies and Winthrop's willingness to give advice free of charge — so far as his studies enable him to do—he was widely consulted for medical advice." Cotton Mather says, "Where-ever he came, still the diseased flocked about him, as if the Healing Angel of Bethesda had appeared in the place." It is as a physician that we will momentarily consider him; his scholarly attainments and his illustrious career as Governor of the Commonwealth can only be mentioned.

In the New Haven Colony as might be expected his clientele numbered the families of Eaton, Davenport and Leete. An extract from a letter of John Endicott to Winthrop gives us some idea of the compounds which he used in his practice. He writes: I have sent you all I have, or what I can gett; viz. Syrup of Violetts, Sirrup of Roses, Spirits of Mint, Spirits of Annis, as you may see written upon the severall vials, I have sent you Mrs. Beggarly her unicorns Horne & Beza stone I had of Mr. Humfrey . . . I have sent you a Be (z) oar stone & mugwart and organie, if you should have need of it."

In 1657 Winthrop was elected Governor of Connecticut which necessitated his removal to Hartford. We are led to believe that the town once more was obliged to call on Mr. Augur for its medical ministrations.

William Westerhouse (or Westerhousen) and Richard Williams were men who also practised medicine in this early period of the Colony's history. The former, a Dutch merchant, took the oath of fidelity in 1648 and from the records it appears that he was primarily engaged in merchantile enterprises and that medicine was more or less a side issue. Richard Williams was an "able or licensed physician" living in Hartford during the winter of 1686-87 when he was induced to take up his abode in New Haven, where it was voted "he shall be welcomed and well accepted in the place." His chief claim to fame seems to rest, not upon his medical honors, but because of his refusal to serve as constable, to which office he was elected in 1692. He not only declined the office but persistently refused to pay the fine of 40 shillings which the law demanded in such cases. The record says he "refused the choice counting it an affront, and alleging that he knew neither law nor custom to justify the choosing him." As far as we know the doctor remained steadfast to the end although in 1694, two years later, the record states that it was "Voted, That the Townsmen "on the Town's behalf manage the case respecting Dr. Williams' fine for refusing to stand Constable, and that they see the law attended as much in them lies."

The first midwives in America were undoubtedly those who practised their art abroad and were brought to New England for that purpose. In John Winthrop's (Sr.) Journal we read June 1, 1630, while aboard the ship *Arbella* that a "woman in our ship fell in travail & we sent and had a midwife out of the *Jewel*" (an accompaning vessel). One of the most famous of these women was the celebrated Anne Hutchinson of Boston, who was spoken of as a person "very helpful in the times of childbirth and other occasions of bodily informities." Her sufferings and misfortunes figure largely in all the early historical accounts in Massachusetts.

When we inquire into the disorders that this group of early doctors were called upon to treat we realize that not only were the diseases of today prevalent at that time but in addition other conditions which modern medical science has largely eliminated. I refer to such diseases as Yellow Fever, Small Pox, and Intermittent Fever. In perusing the Records one is impressed with the frequency of so-called Fevers. This is probably due to the fact that all conditions accompanied with fever undiagnosed as definite diseases were included under this broad definition. It is interesting to consider some of these "Fevers." One of the most serious and widespread diseases that afflicted the New Haven Colonists was Intermittent or Malarial Fever called by them "ague and fever." This disease has so diminished in recent years both in prevalence and intensity that it is hard for us who possess such specific means for its cure to realize its severity in that day.

Hubbard in his History of New England in a chapter headed "The First Planting of New Haven" says "They have been at several seasons sorely afflicted with diseases, especially fevers, which have proved mortal to many. All that southerly part of the seacoast having, as more propinquity to Virginia in situation, so a participation with it in its climatical diseases, commonly there called the seasoning, which is an ague and fever seizing upon men in the heat of summer, chiefly upon new comers, therefore called by that name, but not sparing the more settled inhabitants, especially in case of intemperate drinking." That New Haven maintained until comparatively recent years a reputation for this disease is witnessed by an essay written in 1838 by the famous physician and poet, Oliver Wendell Holmes, who says "it would seem that indigenous intermittent fever can have prevailed but to a very limited extent and the only place which we can clearly point to, as giving origin to the disease, is New Haven.

Small pox was another disease that sorely afflicted the Colonists. In an early sermon by Amos Adams at a fast day April 16, 1769, he declares "and lest after all the savages should prove too hard for them, in 1633 the small pox made dreadful havoc among then and swept away almost whole plantations of Indians." And for thoughts of this kind we can always turn expectantly to Cotton Mather. He says, "The Indians in these parts had newly, even about a year or two before, been visited with such a prodigious Pestilence; as carried away not a Tenth, but Nine parts of Ten (yea, 'tis said Nineteen of Twenty) among them: So that the Woods were almost cleared of those pernicious creatures to make Room for a better Growth." Numerous epidemics of this disease swept over New England during the seventeenth Century and epidemics are recorded for the years 1633, 1666-67-68, 1677-78, 1689-90.

Measles is another disease which in some towns was unusually fatal. Although the next century was visited with severe epidemics, it is reasonable to believe that much of the so-called small pox of the early days was measles in a malignant form. Epidemics of Influenza prevailed throughout New England almost from the beginning. Winthrop refers to an epidemic in 1647; other epidemics occurred 1655, 1660 and 1697-98.

Diphtheria in 1659 ravaged Connecticut to such an extent that at the cessation of the epidemic the Legislature ordered a Day of Thanksgiving. Dysentery, Scarlet and Yellow Fevers were seen from time to time in New England in epidemic form. Packard quotes Winterbotham as saying the diseases most prevalent in New England were "Alvine Fluxes, St. Anthony's Fire, asthma, atrophy, catarrh, colic, inflammatory, slow, nervous and mixed fevers, pulmonary consumption, quinzy and rheumatism."

Medical practice in the early Colonial period was almost wholly an art rather than a science as we know it. Facts and symptoms concerning disease were learned from books rather than from patients and treatment was practically identical in all diseases. The people of that day looked for the supernatural in everything and specific and sovereign remedies were given implicit trust. The practice of medicine by the clergy undoubtedly did much to foster these beliefs.

The early doctors had a great fondness for the use of the lancet and patients were bled in sickness with almost the regularity that the physician of today feels the pulse. Medicines in that day were difficult to secure, either being imported or made from wild herbs. Honey or molasses was used as a syrup or vehicle for the more unpleasant drugs. Some of the mixtures contained as many as 75 substances, the ancestors of what we now call "shot-gun" prescriptions. Holmes reports among the Winthrop papers a list of recipes written by Dr. Ed. Stafford of London and given to Gov. Winthrop for use in his colony in 1643. This may have been the only medical textbook in the Colony. Its perusal gives us some idea of the standards in medicine of that day. It contains, as may be imagined, startling advice such as "For paines in ye Breast or Limmes; Weare a Wilde Catts skin on ye place grieved." For old sores, "Take St. Johns Wort, pound it small and mingle it with as much quicklime: powre on it raine Water, that may cover, six fingers deepe in a broad earthen Vessell, putt it to ye sunne, and stir it well once every day for a Moneth; then filter and reserve the water for your use. Wash ye soares with it; it cureth Wonderfully." These are but mild samples. Boiled toads, eels, and other unsavory and nauseating materials often entered into the horrible mixtures. Feather beds, night caps, and warming pans all had their place; we fear a disadvantageous one. Baths in winter were avoided and to wash the feet in January was supposed by the English to be particularly dangerous to health. Our New Haven Doctor, John Winthrop, used elder, wormwood, anise and other simple remedies and also certain mineral substances. Nitre he used oftener than any other drug ordering 20 to 30 grains for adults. Spermaceti he prescribed after injuries such as sprains and falls. Antimony was another mineral that Winthrop used extensively. Winthrop's celebrated and sovereign remedy was Rubila, a compound of antimony, nitre and "a little salt of tin." In one of Winthrop's letters we are told to "remember that Rubila be taken at the beginning of any illness."

Other remedies were:

"And Epsom salts and senna too, and
hellebore and borax
And herbs and teas for stomach aches,
the bowels and the thorax;
And aloes for cathartics mild, and
ipecac emetics,
Peruvian bark in Holland Gin, for
gentle diuretics."

How different the doctor of that day from the physician of today. He at once combined the professions of medicine, surgery, pharmacy and dentistry, and made his rounds on horseback with saddlebags filled with medicines and instruments. Streams were usually forded, if not, were crossed on crude bridges of hewn logs. After sundown, darkness reigned supreme and for the wayfarer to become lost was no unusual occurrence. Even in the settlements the streets were unlighted except for what light crept through house windows. The only light used out of doors was the cylinder tin lantern, perforated with slits and housing a feeble tallow candle. These are a few of the conditions under which our early New Haven doctor practised.

AUTHORITIES CHIEFLY CONSULTED

Atwater, E.E. History of the City of New Haven; New York, 1887.

Bacon, Francis. The Medical Profession in New Haven. New York, 1887.

Bartlett, Josiah. Progress of Medical Science. Mass. Hist. Soc., Vol. 1, Series II.

Bolton, R. History of Westchester County, New York, 1881.

Bronson, Henry. Medical History and Biography, N.H. Col. Hist. Soc., Vol. II. Chapters on the Early Government of Conn., idem., Vol. III. History of Intermittent Fever in N.H. Region. Proc. Conn. Med. Soc., 1872.

Ferris, H.B. Some Early Medical Teachers in Conn., Bull. Soc. Med. Hist., Chicago, 1923.

Green, S.A. History of Medicine in Mass. Boston. 1881.

Guilford, W.M. Notes and Medical History of Lebanon County. Leb. Co. Hist. Soc., Vol. IV.

Holmes, O. W. The Medical Profession in Mass. Medical Essays, Cambridge, 1891 Facts and Traditions respecting the existence of Intermittent Fever in New England; Boylston Prize Dissertation, Boston, 1838.

Hubbard, Rev. Wm. A. General History of New England, Mass. Hist. Soc., Cambridge, 1815.

Kelly, H.A. and Burrage, W.L. American Medical Biographies, Baltimore, 1920.

Mather, Cotton. Magnalia, Hartford, 1853.

Osler, Wm. Principles and Practice of Medicine, New York, 1912.

Packard, F.R. History of Medicine in the U.S. Phila., 1901.

Redsecker, J.H. Some Doctors of the Olden Time. Leb. Co. Hist. Soc. Vol. I.

Russell, G.W. Early Medicine and Medical Men in Conn. Proc. Conn. Med. Soc., 1892.

Steiner, W.R. Gov. John Winthrop, Jr., as a Physician. J. H. Hosp. Bull,. 1903. Vol. IV.

Steiner, B.C. History of Guilford, Conn. Baltimore, 1897.

Thatcher, J. American Medical Biography. Boston, 1828.

Wadsworth, W.S. Medicine in the Colonies, Penn. Soc. Orders. Founders and Patriots, January 14, 1910.

Winthrop, John. History of New England from 1630-1649 ed. J. Savage, Boston, 1825.

Records of the Colony and Plantation of New Haven.

GOT A MATCH?

You don't need to have, to test for urine sugar with the new "Galatest" method, which dispenses with the need for bunsen burner and other laboratory equipment. A single drop of urine on a few grains of Galatest powder instantly reveals the presence or absence of sugar. You will like it, doctor, and so will your nurse and diabetic patients. Price? Fifty cents for approximately one-hundred tests. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

The Emergency Treatment of Fractures*

CLAY RAY MURRAY, M.D., F.A.C.S.†**
New York, N.Y.

The greatest advances in fracture treatment made in the last twenty-five years have been the institution of fixed traction as an emergency method of splinting in fractures of the long bones, improvement in the emergency handling of spine injuries, and the improvement in the emergency handling of compounding wounds.

The proper emergency treatment of fractures of the long bones does much to minimize the amount of damage to important soft part structures while waiting for definite treatment; it lessens pain and shock to the patient, it simplifies and improves the results of the actual reduction of the fracture, and helps to promote conditions favorable for adequate healing of the fracture.

The proper handling of spine fractures during the emergency period is of tremendous importance in preventing cord and nerve damage or in minimizing the extent of this damage if it has occurred at the time of injury.

The proper handling of compound wounds and of compound fractures during the emergency period, within the first hour of injury if possible, is *the* most important factor in minimizing the risks of infection and delayed and non union.

The ideal form of emergency treatment of fractures of the long bones entails the use of the Thomas or Keller-Blake leg splint and the Murray-Jones arm splint, utilizing traction. The equipment is cheap, the apparatus is simple, and the method is easily and rapidly carried out.

The problem presented in the emergency handling of a fracture of a long bone is two-fold — 1: prevention or minimizing of shock in the patient; 2: fixation of the fragments with the maintenance of as nearly normal length of the bone as possible until definitive treatment can be initiated. The two problems really go hand in hand, and if the second problem is adequately met, the first is largely solved.

We might briefly picture what happens following a fracture in order to get a clear picture of what emergency treatment should do to be effective. Immediately following fracture there is a paralysis of the local musculature and, after the initial sharp pain of injury, a local anesthesia. In the patient's words, the part "feels numb". This lasts for but a short while — from five to fifteen or twenty minutes. During this time, unless attempted by rough and sudden sharp movements, traction and even moderate manipulation can be carried out without pain or resistance on the part of the patient. Many of you have seen this graphically illustrated on athletic fields, where a dislocated shoulder or elbow or finger is readily and practically painlessly reduced by immediate traction by a fellow-player or a trainer. The relaxed muscles and the local numbness make this possible. Immediately following this period, however, the part becomes acutely sensitive and the musculature goes into violent spasm in an attempt to splint the part. If the bone is completely broken across the fragments are pulled past one another to produce over-riding, the ends of the fragments dig into the adjacent muscles causing further tissue damage, the pain and accompanying shock to the patient are increased and the local circulatory spasm and the later inflammatory reaction are intensified. Within a few hours the muscles shortened by spasm are more or less fixed in the shortened position by reason of inflammatory exudate and infiltration by hemorrhage which makes them semi-rigid and lardaceous instead of elastic structures.

---

*Read before the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

†From the Department of Surgery, College of Physicians and Surgeons, Columbia University, and the Fracture Service of the Presbyterian Hospital in the City of New York.

**Associate Professor of Surgery, College of Physicians and Surgeons, Columbia University.

For years the accepted method of emergency splinting was by padded board splints or metal or wooden gutter splints or substitutes therefor. These served to keep the part relatively quiet if firmly enough applied, but did nothing to prevent the shortening of the muscles in spasm, and by their pressure actually tended to increase the circulatory obstruction. They were certainly better than nothing, but they were far from fulfilling the full purpose of emergency splinting, and their application was far from painless to the patient.

Today the use of such splinting in upper and lower extremity fractures is gradually being discarded for the use of fixed traction utilizing the Keller-Blake splint for the lower extremity and the Murray-Jones hinged splint for the upper extremity. These two splints, which take up but little space and cost but little, can now replace the numerous sizes and shapes of padded boards which were formerly used, and do a much more effective job. If properly applied during the early relaxed and numb state of the part they will frequently accomplish reduction by the time the patient reaches the hospital or the office. At the least, they will keep the fragments quiet and maintain the full length of the muscles, preventing over-riding with its attendant tissue damage and pain, and without compression to interfere with circulation in the fracture region. Under these circumstances the actual reduction is much more easily accomplished, since there is little or no over-riding to correct.

If the patient's muscles are already in spasm at the time of application, the application can be accomplished with practically no pain or trauma to the fracture and the fixed traction will overcome the spasm slowly and painlessly before fixation of the shortened muscles by inflammatory infiltration has occurred. Again the actual reduction is simplified, and the relief from pain by relief of muscle spasm is quite striking. It frequently is so effective as to make morphine unnecessary, and always marked enough in its effects to minimize the amount of medication needed.

These are not theoretical considerations. They are facts. They are based on actual study and observation of thousands of cases, and there can be no ground for argument in the matter. Nor is there any excuse for continuing the use of primitive methods of immobilization. There is not the excuse of expense, for the two splints can be secured for less than Five Dollars and are practically indestructable. There is not the excuse of cumbersome apparatus, for the splints can be carried in any car without difficulty, and take up no room in an office. There is not the excuse of difficulty of application, for the application is so simple that a twelve year old Boy Scout can be taught to do it, effectively and painlessly, in a half hour of instruction.

Much of the excellent work which has been done in furthering the proper emergency handling of fractures has been accomplished through the splendid efforts of the Regional Fracture Committee for The State of Connecticut, and by individual workers in that state.

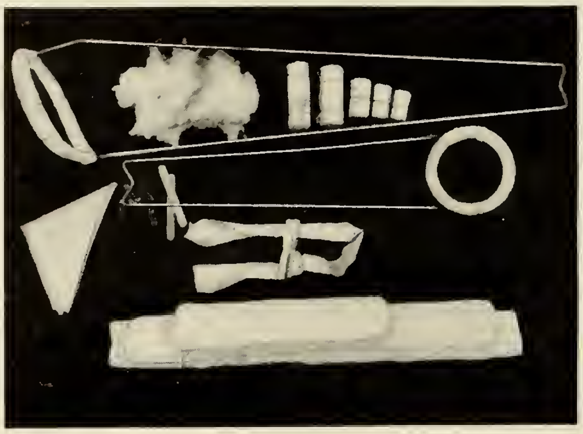


Figure 1.
Emergency Outfit for Fractures.

Full ringed lower extremity splint and hinged ring upper extremity splint. The Keller-Blake half-ring lower extremity splint has only the posterior half of the ring. It is probably preferable to the whole ring splint, since it can be slipped under the extremity from the side, and does not have to be passed over the foot and pushed up along the extremity. Muslin bandages for traction strips and for ties, and cotton for padding. Muslin slings (left) can be used for the ties if preferred. A traction loop (center) is illustrated. Two separate strips tied just snugly about the padding and square knotted, one on each side are simpler. Safety pins. Tongue depressors for Spanish windlass traction. Padded board splints (below).

The application of emergency traction can be very simply described.

1. For the lower extremity.
   a. The patient is placed flat on his back.
   b. The foot is firmly grasped and slow, steady traction is exerted.

c. When good firm traction has been established the foot is slowly rotated, if necessary, so that the patella looks directly upward.

d. While this traction is maintained a padding of cotton or any other material is wrapped about the ankle.

e. Two pieces of muslin bandage are then tied to the ankle, just snug about the padding, one knotted on the outer side, the other on the inner side.

f. The traction on the foot is maintained with one hand until the other takes it by pulling on the two muslin strips. Then the manual traction on the foot can be released.

g. If the half-ring (Keller-Blake) splint is used:

While the traction is maintained the splint is slid under the leg from the outer side, the ring being pushed snug up under the ischial tuberosity.

If the whole ring (Thomas) splint is used:

The traction strips are passed through the ring of the splint, and the ring pushed up the leg and thigh until it comes to rest against the ischial tuberosity, traction being constantly maintained by changing hands as necessary.

h. The two traction strips are passed over the end of the splint, slowly pulled taut and tied.

i. A tongue depressor is passed between the two strips and used as a Spanish windlass to twist them until under good tension.

j. Four wide muslin bandage strips are then snugly tied about the splint and the contained extremity—one between the ankle and the knee one at the knee, one between the knee and the hip and one at the hip. Some support must now be placed beneath the end of the splint so that the heel is kept off the ground. So long as the heel is kept free from the ground or the stretcher or the bed the leg and splint as a unit can now be swung in any direction without disturbing the fracture, and with no fear of pain or damage. Moreover, the muscles cannot shorten, and if in spasm the Spanish windlass traction will slowly relax them.

Figures 2 and 3 show the splint applied.

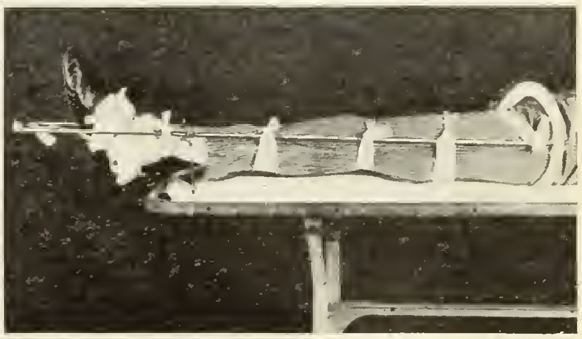


Figure 2.
Lower Extremity Emergency Fixed Traction
Note location of ties. The uppermost one is particularly important if Keller-Blake half-ring splint is used. Spanish windlass traction is best seen in succeeding figure. Note support for splint. This can be done by pillows, blocks or books under the extreme end of the splint just as well. The metal support is a convenience.

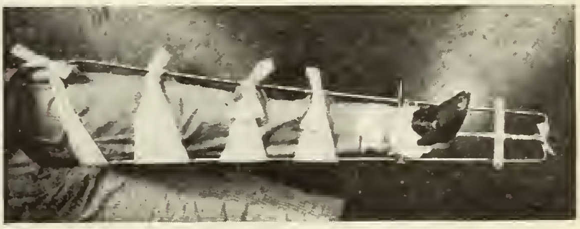


Figure 3.
Lower Extremity Emergency Fixed Traction
Spanish windlass traction well shown.

These splints can be applied over the clothing and without removing the shoe, and on arrival at a hospital or office the clothing can be removed by simply cutting along the seams without disturbing the splint or its traction. The shoe can similarly be removed after unlacing without releasing the traction which is about the ankle above it.

Compare this picture with that shown in Figures 4 and 5

These figures show a lower leg fracture splinted as adequately as it can be by board splints for a fracture of both bones of the leg. The splints extend well above the knee and below the foot, and several turns of the bandage maintain the straight position of the foot. But there is constriction of the whole limb by the snugly bandaged splinting, and unless the

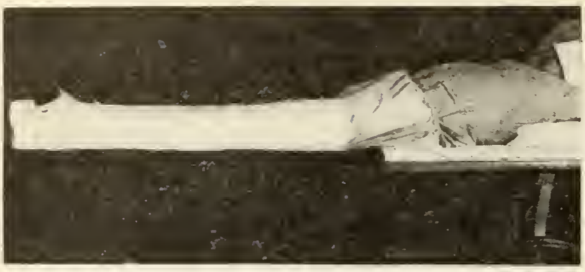


Figure 4.
Padded Board Emergency Splinting for Leg.
Note that splints extend well below the foot and above the knee. If the thigh or the hip is involved the splint on the outer side must extend to the axilla and be bandaged to the chest. The end of the splint beyond the foot must be kept elevated to keep the heel free of the ground or stretcher.

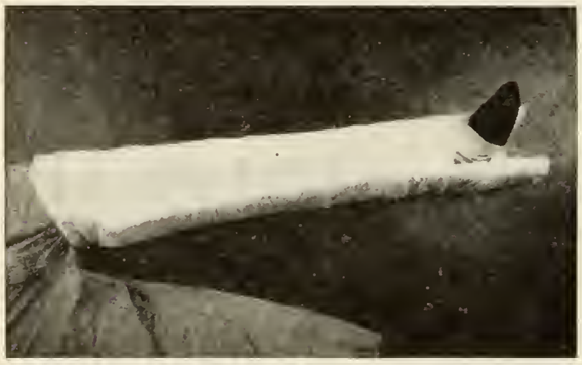


Figure 5.
Padding Board Emergency Splinting for Leg.
Note how foot is maintained in mid-position.

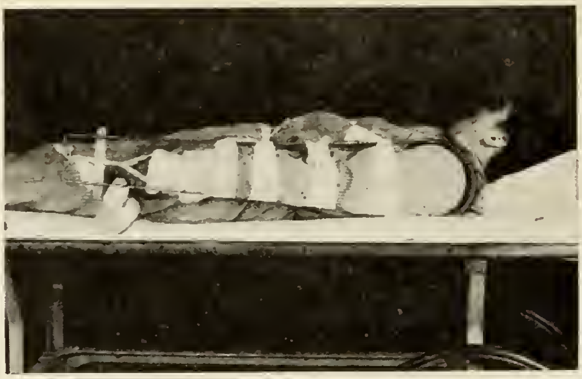


Figure 6.
Upper Extremity Emergency Fixed Traction
Note supported end of splint, padding and Spanish windlass traction, location of supporting ties, and ring up over shoulder with bars of splint in vertical plane.

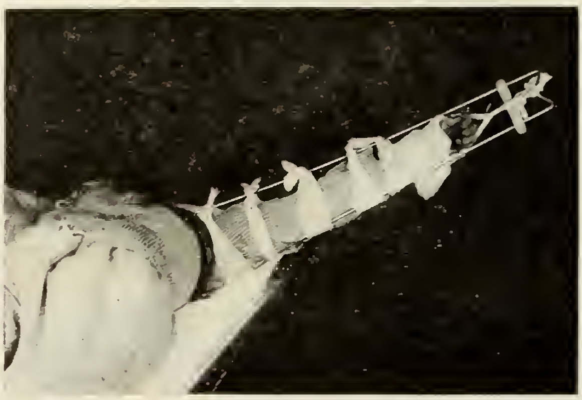


Figure 7.
Upper Extremity Emergency Fixed Traction.
Note range of motion for x-ray, dressing, etc. allowed by hinging of splint. Traction in this position is against the chest wall.

bandaging is tight enough to *seriously* threaten circulation, every movement of the extremity, unless most cautiously done, is painful because of movement of the bone fragments and there is nothing to prevent bone ends from over-riding and the muscles from shortening inside the splints. If they have already done so before the application of the splints, there is nothing being done to correct the condition. Moreover, in order to remove this patient's clothing or to inspect the wound if the fracture is compound, the splints have to be removed. No examination except x-ray can be made without removal of his splint.

If your leg was broken, which method would you prefer for use on yourself?

Figures 6 and 7 show the hinged Murray-Jones arm splint applied, and the range of motion allowed by the hinging for purposes of examination or x-ray without pain or distress to the patient or damage to his fracture or adjacent soft parts. The application of the splint is identical with that of the one for the lower extremity. Initial traction, the placing of the cuff of padding about the wrist, the tying on of the two muslin traction strips, transferring the traction from manual pull on the hand to pull on the strips, passing them through the ring with the arms of the splint in the vertical plane while traction is maintained, sliding the ring up the arm and over the shoulder, pulling the traction strips taut over the end of the splint and applying Spanish windlass traction after they are tied, and finally the application of the four muslin strips, one between the elbow and the wrist, one at the elbow, one between the elbow and the shoulder, and one high up at the shoulder. In the illustration it will be noted that the end of the splint rests on a support so that the hand does not rest directly on stretcher or bed or ground.

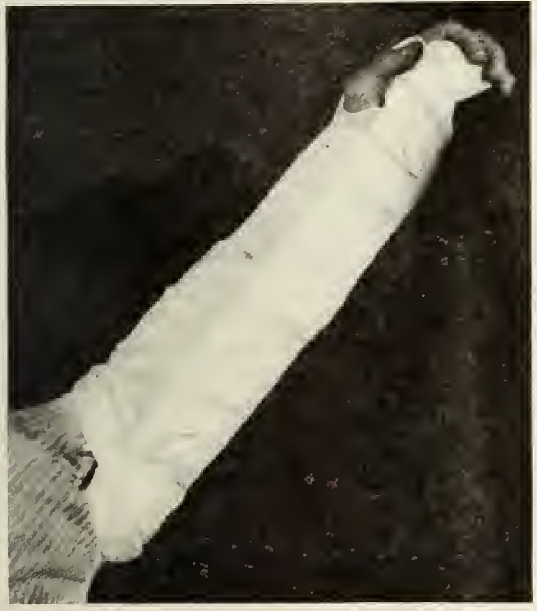


Figure 8.
Padded Board Emergency Splinting for Forearm.
Note that splints extend well up the upper arm, and well beyond the wrist. If humerus or shoulder is involved the palmar splint must extend to the axilla and the dorsal splint beyond the shoulder, and the whole extremity must be bandaged to the chest wall to get any approach to immobilization.

Again for comparison, Figure 8 shows adequate board splinting for both bones of the forearm, extending well above the elbow and below the wrist. The comparison between these two methods in the upper extremity is exactly that made between the two for the lower extremity.

In fractures of the dorsal or cervical spine the great danger is that of injury to the cord. Neurological surgeons who see these cases are convinced that in many instances the cord damage is either inflicted by or markedly aggravated by the initial handling of the case. Somebody sits the patient up to give him a drink, thereby flexing his spine and crushing his cord; or they rush him to a hospital or a doctor's office sitting slumped in the back seat of a car — by the time he reaches the hospital or the office his legs are paralyzed; if he is put on a stretcher he is lifted by shoulders and legs and placed face up on the stretcher, both of these procedures again effectively flexing his spine and threatening, if not producing, cord damage.

It is true that the initial mistakes are usually made by the well intentioned layman bystander, but it is equally true that too frequently our ambulances, accident wards and x-ray departments repeat that mistake, successively, to the detriment of the patient. By a few simple precautions we can at least avoid going from bad to worse. In addition, whenever the opportunity presents we should all be willing to aid in the instruction of the laymen through such organizations as first aid classes, Red Cross and Boy Scout classes, Police and Fire Department personnel, and school athletic personnel. Your State Society organization and your Regional Fracture Committee will be glad to avail themselves of your help and cooperation. Moreover, each of you who has a hospital connection has a great opportunity, and a moral responsibility, to see that adequate emergency treatment is in use for all fractures in your institution. It is only through such individual cooperation on your part that the efforts of any committee can be successful. And, I cannot stress too strongly the importance of the cause in which you will be working.

The proper emergency handling of back injuries is a simple matter. When a patient has been hurt under circumstances that can produce back or neck injury and is unconscious, it is wise to assume the possible presence of that injury, even though on first examination there may be no positive signs. If the patient is conscious and complains of pain or distress in the back or in the neck, he should be handled as though injury were present until *proven* otherwise. If the complaint is of back pain, make sure that he can move his feet and legs voluntarily. If he can, one can assume that there has been no severe cord damage up to that time. If the complaint is referred to the neck, the fact that the patient can open and shut his hands will similarly insure the condition of the cervical cord. It is important from the standpoint of later treatment to know whether cord damage dates from the time of injury or develops gradually after injury. Whether or not cord symptoms are present the patient should be handled as follows:

Suspected back injury:

These cases must be transported and handled during x-ray and other examinations, until actual treatment is instituted, face down, in so far as possible. Any turning which has to be done must be accomplished by turning the trunk as a whole from hips to shoulders. Turning may be necessary in order to obtain the initial face down position, in order to get lateral x-rays, etc.

If, when originally seen the patient is on his back or on his side, a blanket folded lengthwise should be placed on the ground alongside him and he should be rolled onto it face down by grasping the clothing at the hip and shoulder and turning the trunk as a unit. Twisting or flexion of the dorsal spine can thus be avoided. If he is already lying face down when seen the blanket should be placed alongside of him, and by grasping the clothing at shoulder and hip, he should be pulled onto the blanket, again moving the trunk as a unit. Once on the blanket, face down and turned to one side, he can be lifted by a two or four man carry and placed on a stretcher or bed. Whatever sagging of the blanket, stretcher, or bed occurs tends to cause extension of the spine instead of flexion.

Suspected neck injury:

In this case the patient should be placed on his back and transported on a flat unyeilding surface with the head held in mid-position, and preferably with gentle traction. This is the best method of preventing neck flexion or cervical spine twisting. If the patient is on his side or face down, the legs should be gently straightened, and then gentle pull should simultaneously be made on the head and the legs. When gentle but firm traction has been established the turning of the body as described for back fractures should be carried out by another individual, the feet and head being turned in union with the body turn by the individuals maintaining traction on the head and feet. During this turning no flexion of the neck must be allowed to occur. If the head is not in mid-position it should then be slowly turned into that position while traction is maintained. Any flat board — a door, an ironing board, or any other board five or six feet long that is available — should then be placed alongside the patient, and the patient should be pulled onto the board by the individual who had previously accomplished the turning of the trunk, the traction on feet and head being maintained, and the head and legs being moved in unison with the body. The arms are then folded over the patient's chest and he is tied or strapped to the board and rolled up clothing or other supports placed on either side of the head to maintain the mid-position. It is advisable, if possible, to maintain the head traction until treatment is established. Even if the traction is not maintained, the neck is kept thus in extension and in the mid-position during transport and x-ray and other examinations.

If, when originally seen, the patient is on his back the traction is established and from then on the procedure is as described above.

If, before and after arriving at a hospital or doctor's office, such procedures for back and neck injuries can be established, the number of cases incurring cord damage, and the amount of cord damage incurred, can be greatly decreased. And, to all of you who have had to follow the unfortunates who have sustained cord damage with back or neck injuries, this would represent a tremendous blessing.

The third great advance made in recent years in fracture treatment is in the emergency handling of compound fractures.

In the first place, the use of fixed emergency traction as previously described for simple fractures of the long bones has been of great advantage. There has been in the past considerable difference of opinion as to whether protruding fragments should be pulled back into place by the application of emergency traction. The pros and cons of this question have been carefully considered, and today the great majority of men who have many compound fractures to treat agree that the more effective immobilization of the fragments secured by this method and the superior protection afforded to the soft parts more than offset any theoretical danger of carrying contamination on the bone ends deep into the tissues. There are only two possible exceptions to this general rule. These are: 1. If the case is going to have to wait many hours before wound debridement; 2. If the ends of the bone are grossly contaminated by ground-in dirt from street or road. Even under these circumstances the objection to fixed traction is theoretical rather than practical, and the best general rule to follow is to apply fixed emergency traction whether the fracture is simple or compound.

In the second place we have to recognize the importance of time as a prime factor in determining whether or not a compound fracture becomes infected — the time elapsing between the injury and the actual treatment of the wound. The immediate treatment of the wound during the emergency splinting should be merely the application of a sterile dressing.

The initiation of treatment in a simple fracture is considered in terms of *hours* after injury. The initiation of treatment in a compound fracture must be considered in terms of *minutes* after injury. In the first instance we want to get our reduction and fixation before the inflammatory infiltration of muscles and soft parts becomes too far advanced. In the second instance we want to get our wound treatment started before surface contamination by organisms develops into tissue invasion by organisms. If we can do that we can by adequate debridement and wound cleansing remove the major element of contamination and the dead and devitalized tissue in which organisms feed and prosper most rapidly, leaving healthy tissue with a minimum of organisms to contend with. If we delay our attack until the sound tissue planes have already been invaded the chances of a clean wound are naturally greatly lessened. Indeed, in the minds of many it is very questionable as to whether any debridement should be done in a compound wound after the elapse of ten to twelve hours. The tissues are already deeply invaded by that time, and any attempt at debridement may merely open up new channels for further dissemination of the infection. It is perhaps better at that time to consider the wound infected, and to treat it as an infected wound by adequate drainage.

The actual invasion of the tissues *starts* in the first hour, however, and with every half hour thereafter our chances of avoiding infection diminish progressively, no matter how excellent a debridement is done. Debride, therefore, within the first hour if possible; and calculate in terms of minutes thereafter. There is no exaggeration in this statement. It is *literally* true.

The debridement itself must be done according to definite plan. It has the definite purpose of removing all surface contamination and all dead and devitalized tissue, of eliminating all dead spaces, of sparing all sound tissue, and of inflicting as little additional trauma as possible.

In the minds of many the existence of shock in a patient is a contra-indication to wound debridement and fracture reduction. They feel that these procedures should be delayed until the patient has recovered from shcok. This is not only an illogical viewpoint — it is also an unphysiological one. Certainly shock is an important consideration and one not to be ignored without seriously risking the patient's very life. But, if proper evaluations are used, and adequate shock treatment used on the basis of those evaluations, the treatment of shock and the treatment of the wound and the fracture can be carried out simultaneously without harm to the patient with the few exceptions which I will name later.

Consider, however, the state of a patient in shock if it is felt that his shock must be successfully combatted before anything can be done about his wound or his fracture. He has a compound fracture in which every hour of delay diminishes his chance of escaping infection. Four, six, eight, ten hours go by during which his shock is being treated. By that time the value of debridement is greatly lessened or completely destroyed. The debridement and fracture reduction are then done, again subjecting the patient to shock for which he again has to be treated. He has been "picked-up" and put on his feet, so to speak, to be again knocked down by a procedure which has lost much if not all of its value by the time it has been done. It doesn't sound sensible, and it certainly ignores physiology.

Contrast this patient with one who comes in with a compound fracture and in shock. While the operating room is being prepared he is given whatever medication is necessary, he is kept warm, and rapid determination is made of his hematocrit index, his plasma protein values and the plasma specific gravity. These can be done in a few minutes, and very simply, by modern methods, and give definite indications as to whether the patient should receive normal saline, hypertonic glucose, whole blood, or a combination, to meet his specific needs. By the time the operating room is ready the necessary set-up can be assembled, and his specific shock therapy can be instituted simultaneously with the treatment of his injury. Additional treatment can be given as indicated by additional testing during the course of the operation. When the patient is sent to his bed his wound has been debrided in time for the procedure to have been of value, his fracture has been reduced and he need be subjected to no further shock. And, if indicated, his specific shock therapy can be continued. Certainly a more pleasing picture — and a real, not a theoretical one.

The exceptions, which cannot be subjected to this course, are the really moribund patient, and those in whom the compound fracture is accompanied by severe head injury, crushing chest injuries, or intra-abdominal injuries.

As to the debridement itself it should be meticulously done. With the limb in its traction splint or under manual traction, the wound should be gently plugged with sterile gauze, and the skin for a wide area should be cleaned *thoroughly* with green soap and water, alcohol and ether successively, after shaving. A skin antiseptic can then be applied if we are certain that it is weak enough not to damage the skin, and provided we rely on the cleansing rather than the antiseptic for protection.

The gauze plug is then removed from the wound. Using a sharp scalpel and a pair of forceps the skin edge is then excised for one-eighth of an inch or more as indicated by skin damage and contamination. The instruments are then changed or cleansed, and the skin wound is enlarged to the extent of the underlying soft part damage. The subcutaneous tissue is then debrided circumferentially, removing only dead or devitalized tissue back to the first evidence of healthy bleeding tissue. Again the instruments are changed or cleansed, and the fascial layers debrided. Similarly, with fresh or cleansed instruments, the successive muscular and fascial layers are debrided down to periosteum and bone. Only obviously devitalized or grossly contaminated bone and periosteum are removed All dead spaces are eliminated, and the wound is then lavaged from within out, using a small soft catheter passed to the bottom of the wound and normal saline. Too much saline can not be used. It should be measured in gallons, not in quarts. No antiseptics should be used in the wound.

After this thorough lavage, the fracture should be reduced and the method for holding the reduction decided on. This question, as well as the question of whether or not the wound should be closed primarily or, if left open, what subsequent wound treatment should be used, are debatable points, and do not belong in a discussion of emergency measures. I myself do not believe in the primary closure of any compound wound except under very unusual circumstances.

It shall be remembered that it is particularly important to get as rigid immobilization of the bone fragments in a compound fracture as is possible if we are to minimize the risk of osteomyelitis.

These, then, are the chief points in the emergency handling of fractures. If the methods here advocated could be universally adopted, the treatment of fractures would be greatly simplified, and the results of treatment would be immeasurably better than they are in general today. It is in the power of each one of you to help towards this end. It is only through the help and cooperation of all the men who treat fractures that the end can be attained.

* * *

VITAMIN-FREE FOODS FOR RESEARCH

A recent announcement by the Research Laboratories of the S.M.A. Corporation reveals that they are now in a position to provide vitamin-free casein and other vitamin-free foods for experimental purposes to researchers who have previously been obliged to manufacture these items for private use.

For many years the S.M.A. Corporation has been producing these foods exclusively for use in their laboratories. Now, with the expansion of their own facilities and the realization of the convenience to others engaged in laboratory work this offer is made to provide vitamin-free diets at an exceptionally reasonable cost. Quantities of one, five, ten or 100 pounds or more may be ordered directly from the Research Laboratories, S.M.A. Corporation, Chagrin Falls, Ohio.

The Results of Four Types of Therapy in 165 Cases of Pneumonia

PETER J. STEINCROHN, M.D.
Hartford, Conn.*

The purpose of this article is to report the results in a series of 165 cases of pneumonia which were treated at the Municipal Hospital on the Medical service of the author. These patients were treated in the months of February, March, and April in the years 1934 to 1939, inclusive.

Although the series is small, it is interesting because the figures used in evaluating the statistics are based on the study of the results of four types of treatment: 1. Routine; 2. Concentrated glucose intravenously; 3. Serum; 4. Sulfapyridine.

A. Routine Management:

The following orders were routine before the advent of serum or sulfapyridine therapy:

1. Sputum for pneumococcus typing.
2. Sputum for tuberculosis bacillus.
3. Blood culture.
4. Portable x-ray of chest.
5. Blood pressure every second day.
6. Hemoglobin, Red and White Blood Cell determination on admission.
7. Oxygen.
8. Codeine Sulphate grains ½ every four hours when necessary for cough.
9. Morphine Sulphate and Atropine Sulphate.
10. Caffeine Sodium Benzoate when necessary.
11. Turpentine Stupes, Flaxseed poultices, rectal tube or Pitressin for abdominal distention.
12. Fowlers position.
13. Ice cap to head.
14. Enema every two to three days.
15. Force fluids with accurate measure of intake and output.
16. Digitalis not to be given unless there is cardiac failure.
17. 200 grams of dextrose and the juice of two lemons in 1000 cubic centimeters of water daily.
18. Citrocarbonates, two drams every four hours until the urine is alkaline.
19. Modified soft diet when the patients temperature has been normal for seventy-two hours.

B. Concentrated Glucose Therapy:

This consisted of giving the patients 50cc of 50% dextrose intravenously twice daily in addition to the routine treatment outlined above. Alternate cases were given this additional therapy.

C. Serum Treatment:

The amount of serum given ranged from 10,000 to 120,000 units. In the last few years no serum treated case received less than 100,000 units. These doses are small in light of present serum therapy.

D. Sulfapyridine:

The first dose was two grams. Then one gram was given every four hours until twenty-five grams had been taken. The drug was administered again if the disease was complicated by a secondary spread of infection. It was administered in milk, orange juice, or apple sauce and was preceded or followed by ½ teaspoon of sodium bicarbonate. Determinations of hemoglobin and complete blood count were made daily while the drug was being given. Serum concentrations of the drug were also studied. (Through courtesy of Dr. L. Hastings at the St. Francis Hospital).

Twenty cases which had been discharged with a diagnosis of either lobar or bronchopneumonia were not included in this study because they did not have sufficient criteria to make the diagnosis certain. Our criteria for inclusion in this series were: 1. Typical onset with chill, fever, pain in chest, cough, and rusty sputum. 2. Positive physical findings. 3. Positive x-ray findings. 4. Positive sputum or blood culture. 5. Confirmatory post mortem findings in those patients who expired. No case with negative sputum was admitted unless there were positive history, physical, and x-ray findings.

---

*Donald B. Blume, M.D., interne, Municipal Hospital, Hartford, collaborated in securing data for this article.

The mortality rates will be listed as unrevised and revised mortality. Under the latter heading, all cases are thrown out of the tables who died within twenty four hours of admission. In this way a more accurate comparison of the results of treatment in the various years can be determined.

1934

Table 1.	*Unrevised Mortality*	*Revised Mortality*
Total number of patients	27	25
Male	16	15
Female	11	10
Recoveries	19	19
Male	12	12
Female	7	7
Deaths	8	6
Male	4	3
Female	4	3
Mortality Rate	29.6%	24%
15 cases glucose treated	(6 deaths)	40%
10 cases routinely treated	(0 deaths)	0%

Table 2 **Age Limits—12 to 89 years**

Age Range	*Number Cases*	*Mortality*
12 — 19 years	4	0
20 — 29 years	1	0
30 — 39 years	2	0
40 — 49 years	6	2
50 — years	5	2
60 — 69 years	6	2
70 — 79 years	2	2
80 — 89 years	1	0

Resume of Types

Table 3.	*Number Cases*	*Mortality*
Type I	2	1
Type II	1	0
Type III	3	2
Type VIII	2	0
Group IV	7	2
Undetermined Sputum	12	3

Revised Mortality

The following two cases were not included in this revised list:

1. Sixty three year old female, ill seven days before admission. Had arteriosclerotic heart disease with decompensation. Expired twelve hours after admission.

2. Sixty two year old male, ill ten days before admission, Type I. Died sixteen hours after admission.

The six patients who died received concentrated glucose therapy intravenously. There were no deaths in the routine treated cases.

An average of 11.3 days elapsed before the temperature dropped to normal and remained there. The total case range was two to forty-five days.

In patients who expired, the admission temperature range was 101.6 to 106.6. The admission range in those who recovered was 100.4 to 105.2.

The range of the number of days of illness before admission in those who recovered was one day to three weeks, the average being seven days. In those who died the pre-admission range was two to ten days, averaging five days illness before admission.

1935

Table 4.	*Unrevised Mortality*	*Revised Mortality*
Total number of patients	32	28
Male	14	12
Female	18	16
Recoveries	20	20
Male	10	10
Female	10	10
Deaths	12	8
Male	4	2
Female	8	6
Mortality Rate	37.5%	28.4%
Treated with glucose	(15 cases, 4 Deaths	26.6%
Routine treatment	(12 cases, (4 Deaths)	33%
Serum treatment	(1 case. Type II recovered	0%

Table 5. **Age Limits—17 to 77 years**

Age Range	*Number Cases*	*Mortality*
17 — 19	1	0
20 — 29	2	1
30 — 39	4	0
40 — 49	6	2
50 — 59	11	3
60 — 69	5	4
70 — 79	3	2

Resume of Types

Table 6.	*Number Cases*	*Mortality*
Type I	1	1
Type II	2	
Type III	3	2
Group IV	1	
Type VII	1	
Undetermined sputum	24	5

The following four cases were not included in the revised table:

1. Female, age 51, negative sputum, ill twenty-one days before admission (routine treatment) expired four hours after admission.
2. Female, age 65, negative sputum, ill one day before admission (routine treatment) expired twenty-two hours after admission.
3. Male, age 62, Type II, ill three days before admission (routine treatment) expired in sixteen hours.
4. Male, age 45, negative sputum, ill four days before admission expired twenty hours after admission.

The following case was included in the revised table:

Male, age 48, Type III sputum and blood culture, ill two days before admission (glucose therapy) died in 36 hours.

Results of Treatment: Four died with routine treatment and four died with the glucose therapy.

An average of 7.5 days elapsed before the temperature dropped to normal and remained there. The total case range was two to twenty-four days, excluding one patient whose temperature remained elevated for seventy-four days due to a complicating lung abscess.

The temperature range on admission of patients who expired was 103.6 to 105.8. The temperature range on admission of patients who recovered was 100.6 to 105.4.

The range of the number of days of illness before admission in the recovered cases was from one day to three weeks, averaging seven days. In those who died the preadmission range was two to ten days, averaging 5.3 days.

1936

Table 7.	*Unrevised Mortality*	*Revised Mortality*
Total number of patients	35	
Males	24	
Females	11	
Recovered	23	
Males	15	
Female	8	Identical
Deaths	12	
Males	9	
Females	3	
Mortality	34.2%	
Mortality (Glucose treat.)	31.2%	
Mortality (Routine treat.)	44.4%	
Mortality (Serum treat.)	33.3%	

Table 8. **Age Limits—10 to 74 years**

Age Range	*Number Cases*	*Mortality*
10 — 19	4	1
20 — 29	4	1
30 — 39	5	1
40 — 49	8	1
50 — 59	5	1
60 — 69	6	4
70 — 79	2	2

Table 9. **Resume of Types**

	Number Cases	*Mortality*
Type I	6	2
Type II	4	1
Type III	2	1
Group IV	10	3
Type VII	2	2
Undetermined	11	3

Revised mortality: 34.2%. Two deaths were admitted to the revised mortality for this year as they died thirty-two hours after admission. There were no exclusions.

Nine cases were treated with serum, three of whom died: One case was Type I and two were Type VII. The patient with Type I was ill 14 days before admission. One case with Type VII had a positive blood culture with illness three weeks before admission. The other Type VII was ill five days before admission.

The serum treated cases that recovered averaged 3.5 days illness before admission. The recovered Types were: Type I, three cases; Type II, three cases.

An average of 10.5 days elapsed before the temperature dropped to normal and remained there. The total case range was three to twenty-five days.

The temperature range on admission on those who expired was 103 to 107. The range on the patients who recovered was from 100.8 to 105.6.

The history of the number of days of illness prior to admission in those who recovered ranged from one day to three weeks, averaging 4.1 day. In those who died there was a history of an average of 11.9 days illness before admission.

Table 10.	1937 Unrevised Mortality	Revised Mortality
Total number of patients	33	32
Males	24	23
Females	9	9
Recovered	23	23
Males	17	17
Females	6	6
Deaths	10	9
Males	7	6
Females	3	3
Mortality Rate	30.3%	28.1%
Glucose Treatment (15 cases)		53.3%
Routine Treatment (10 cases)		10.0%
Serum Treatment (7 cases)		.0%

Table 11. **Age Limits—12 to 82 years**

Age Range	*Number Cases*	*Mortality*
12 — 19	3	0
20 — 29	1	0
30 — 39	4	1
40 — 49	7	1
50 — 59	6	2
60 — 69	7	2
70 — 79	3	3
80 — 89	1	1

Table 12. **Resume of Types**

	Number Cases	*Mortality*
Type I	7	
Type II	4	1
Type III	2	1
Group IV	12	5
Type VII	1	
Undetermined	7	2

One patient was excluded, age 76 (Routine treatment) who died sixteen hours after admission.

The serum treated cases all recovered. (Type I, 5 cases; Type II, 2 cases). The average days of illness was 2.5 before admission.

An average of 8.7 days elapsed before the temperature dropped to normal and remained there. The total case range was two to thirty-five days.

The temperature range on admission of those who expired was 103.2 to 104.8. The range on the patients who recovered was 102 to 105.4.

The history of the number of days illness prior to admission in those who recovered ranged from one to ten days, averaging 3.6 days. In those who died there was an average preadmission illness of 4.3 days.

Table 13.	1938 Unrevised Statistics	Revised Mortality
Total number of patients	9	8
Males	6	5
Females	3	3
Recovered	5	5
Males	2	2
Females	3	3
Deaths	4	3
Males	4	3 (2 of these died in 32 hours)
Females	0	0
Mortality	44.4%	37.5%
Glucose treatment (3 case)		66.6%
Routine treatment (5 cases)		20.0%
Serum treatment (1 case)		100.0%

Table 14. **Age Limits—10 to 79 years**

Age Range	*Number Cases*	*Mortality*
10 — 19	0	0
20 — 29	0	0
30 — 39	1	0
40 — 49	0	0
50 — 59	5	3
60 — 69	1	0
70 — 79	2	1

Resume of Types

Table 15.	*Number Cases*	*Mortality*
Type I	3	2
Type II	0	0
Type III	1	1
Group IV	3	1
Type VIII	1	0
Undetermined	1	0

One case was excluded from the revised list. He was a 53 years old male, ill four days before admission. He had Type I positive blood culture and died in four hours. He received only 120,000 units of serum.

An average of 9 days elapsed before the temperature dropped to normal and remained there. The total case range was six to fourteen days.

The temperature range on admission of those who expired was 103.8 to 105. The range on the patients who recovered was 102.8 to 105.

The history of the number of days illness prior to admission in those who recovered was an average of 5.2 days. The range was from one to ten days. In those who died the average preadmission illness was five days.

Summary for Years 1934 to 1938
(Routine, Glucose, and Serum Treated)

Mortality

Table 16.	Rate
All cases	34.8%
Revised	30.2%
Excluding Serum	35.0%
Without Complications (51 cases, 9 deaths)	17.6%
With Complications (83 cases, 35 deaths)	42.1%

Table 17 Age Limits

Age Range	Number Cases	Deaths	Mortality Rate
10 — 19	12	1	8.3%
20 — 29	8	2	25.0%
30 — 39	16	2	12.5%
40 — 49	27	6	22.2%
50 — 59	32	11	34.2%
60 — 69	25	12	48.0%
70 — 79	12	10	83.3%
80 — 89	2	1	50.0%

Table 18. Resume of Types

Type	Number Cases	Deaths	Mortality
Type I	19	6	31.6%
Type II	11	3	27.2%
Type III	11	7	63.6%
Group IV	33	11	33.3%
Type VII	4	3	75.0%
Type VIII	3	0	.0%
Undetermined	55	16	29.0%

Complications which co-existed with pneumonia and caused the mortality rate of 42.1% against 17.6% in the uncomplicated cases were as follows: rheumatic heart disease, hypertensive or arteriosclerotic heart disease, with or without auricular fibrillation; diabetic gangrene; luetic heart; bronchial asthma; measles; alcoholism with cirrhosis of the liver; coronary artery sclerosis with occlusion; phlebitis; diabetes; Buerger's disease; acute encephalitis; chronic nephritis; carcinoma of the stomach with metastasis; and delirium tremens.

In all patients below the age of 60, the mortality rate was 20.4%; in those over 60, the rate was 60.3%.

The average number of days for the temperature to drop to normal and stay there in all cases was 9.4 days.

The average days of illness before admission in those who recovered was 5.5 days; in those who expired 6.3 days.

There were three deaths in the seventeen serum treated cases giving a 17.6% mortality. In this group there were six cases of Type II, nine cases of Type I, and two cases of Type VII. Of the three who died, one was Type I with a history of 14 days illness before admission, the other two were Type VII, one of which had a positive blood culture.

In the glucose treated cases, there was a total of 65 cases. Of this group, twenty-five died giving a mortality of 38.4%.

There were 52 cases treated routinely, of which 17 died, giving a mortality of 32.4%.

Of the entire group 84 were males of whom 28 died giving a mortality rate of 33.3%. The total number of females was 52, of whom 18 died, giving a mortality rate of 34.6%.

1939

Table 19.	Unrevised Mortality	Revised Mortality
Total number of patients	29	24
Male	21	19
Female	8	5
Recovered	22	22
Males	18	18
Female	4	4
Deaths	7	2
Male	3	1
Female	4	1
Total Mortality	24.1%	8.3%

Table 20. Age Limits—13 to 90 years

Age Range	Number Cases	Deaths	Revised Mort.
13 — 19	3	0	0
20 — 29	4	0	0
30 — 39	4	0	0
40 — 49	3	0	0
50 — 59	2	0	0
60 — 69	5	2	0
70 — 79	2	2	0
80 — 89	5	2	2
90 — 99	1	1	0

Table 21. Resume of Types

Types	Number Cases	Mortality
Type I	3	0
Type II	1	0
Type III	4	2 (Ages 71,—72, One had positive blood)
Type IV	1	0
Mixed (21 and 31) (1 and 6) (1 and 13) (6 and 24)	4	0
Group IV (Indeterminate and V, VI, VII, VIII, and XXV	16	5 (Ages: 69, 90) 80, 60, and 82

The following cases were not included in the revised statistics:

1. E. C., Female aged 72, ill nine days before admission. Had positive Type III blood culture. Empyema and acute pericarditis found at post-mortem. Expired 12 hours after admission, received 4 grams of sulfapyridine.
2. C. B., Female aged 60, ill 4 days before admission. Tremendous distention and exceedingly toxic. Received 4 grams of sulfapyridine, but died in 12 hours.
3. S. W. Male aged 90. Temperature fell in sixteen hours to normal and remained so five days. Died of uremia and cardiac failure.
4. N. G. Female aged 69. Temperature dropped in 28 hours and remained normal. Died on 10th hospital day of cerebral thrombosis.
5. W. W. Male aged 71, died 24 hours after admission. Had been discharged as having arteriosclerotic heart disease with angina pectoris four days before his readmission.

The average age of all patients treated with sulfapyridine was 52.3 years. Almost 50% of the patients treated were over 60 years old. There were no deaths in the 16 patients under 60. In the revised list, there were no deaths until the 80 to 90 limit was reached.

In those who recovered the average illness before admission was 4.5 days, the range in all being one to fourteen days. There was an average pre-admission illness of 4.8 days in those who died, the range being three to nine days.

The sulfapyridine concentration in the blood was as follows: In the recovered cases, average 4.8 milligrams per 100 cubic centimeters volume with a range of from 1. to 11.9 milligrams per 100 cubic centimeters volume. In the expired cases there was an average of 7.6 milligrams with a range of 5.3 to 10 milligrams per 100 cubic centimeters volume.

An average of 20.8 hours elapsed before the temperature dropped to normal and remained there. The range was 4 to 48 hours. Two cases were not included: one required seven days and the other twelve days to reach normal. Both recovered. The latter case was one with associated complications of CNS lues and paralysis of the urinary bladder with marked intractible abdominal distention. When these are included, the average time for the temperature to fall to normal was 1.6 days.

Four patients had secondary rises of temperature. The rise came 4,10, 4, and 12 days after the temperature had remained normal.

There was one patient with positive blood culture in this series: Ages 72, Type III, died in twelve hours.

Response of Leucocytes to Sulfapyridine Therapy

The red blood cell count and hemoglobin were not affected by this therapy. However, the effect on the leucocytes did not correspond with other findings published in the literature.

In the majority of our cases which were treated with sulfapyradine, the leucocytic response was interesting in that the administration of the drug was followed by a lowering of the white blood count within 24 to 48 hours.

The leucocyte findings listed in the table represent those taken during the first forty-eight hours after admission. The differential counts are not listed as there was no case of neutropenia. These varied from 62/38 to 98/2.

Table 22.

Case	*WBC before Administration*	*WBC after Administration*	*Results*
Case 1	13,500	14,800 11,150 7,650	Recovered
Case 2	19,530	7,950	Recovered
Case 3	47,350	21,050 9,650	Recovered
Case 4	43,500	41,400	Recovered
Case 5	9,950	9,150	Recovered
Case 6	27,000	6,800	Recovered
Case 7	16,700	7,450	Recovered
Case 8	15,900	6,050	Recovered
Case 9	10,350	9,350	Recovered
Case 10	19,000	12,050	Recovered
Case 11	12,650	7,270 6,400	Recovered
Case 12 (82 years old)	13,150	11,450	Expired
Case 13 (72 years old)	9,000	not done	Expired (12 hours)
Case 14 (60 yeras old)	23,600	28,000	Expired (20 hours)
Case 15	2,750	1,950 5,650	Expired
Case 16	24,850	14,100 7,300	Recovered
Case 17	13,800	10,500 9,050	Recvoered
Case 18	17,000	21,400	Recovered
	Had another spread of infection.		
Case 19	23,000	17,000 11,700	Recovered
Case 20	33,850	34,000 12,050 11,550	Recovered

Case 21	8,600	11,350	Expired
		15,150	
Case 22	21,000	11,900	Recovered
		9,250	
Case 23	14,000	9,900	
		6,200	Recovered
		4,800	
Case 24	24,000	11,500	
		2,800	Recovered
		7,000	
		9,800	
Case 25	47,850	18,400	Recovered
Case 26	16,150	9,400	Recovered
Case 27	21,600	15,650	Expired
(Recovered from pneumonia, Died of Cerebral Thrombosis nine days after temperature was normal)			
Case 28	15,450	2,400	
		1,500	Expired
		1,450	
		3,200	
		12,800	

It was noted that with two exceptions the leucocyte count dropped in every patient that recovered. This fall was definite in every one of the recovered cases within forty-eight hours following the administration of the drug. In some cases the change was small, while in others it was quite marked. The range of fall within 24 to 48 hours after treatment in these cases was from 800 to 30,000 W.B.C. per cm. The exceptions were: one case in which the counts rose from 17,000 to 21,400 because of infection spread; in the other patient who recovered the original count of 13,500 rose to 14,800 in 48 hours.

Seven cases were admitted to the series as deaths in the unrevised mortality table. In the first case only one count was made as the 72 year old patient died in twelve hours. In the second case (82 years old) the count fell from 13,150 to 11,450. In the third, it rose from 23,600 to 28,000. In the fourth it fell on the second day and again rose. In the fifth, it rose from 8,600 to 15,150. The W.B.C. count fell in the sixth case, but here the patient recovered from his pneumonia, and died later from a cerebral thrombosis. In the seventh case, the drop was marked, but was followed by a rise before death.

Thus, in the five patients who died of pneumonia in whom repeated W.B.C. determinations had been made, it was found that there was a fall in three, but a subsequent rise in two of these. In the other two expired cases in which counts were made, there was a definite rise in the count.

The following two cases illustrate reaction of the W.B.C. to Sulfapyridine:

Case I.: E.F., an 80 year old woman was admitted in collapse with bi-lateral broncho-pneumonia of four days duration (Type XIV). Sulfapyridine was administered immediately. Her temperature fell in sixteen hours and her reaction subjectively was as dramatic as the sharp fall in temperature. Through an oversight her white count had not been taken until the second day. It was found to be 2, 750 WBC, Differential 80/20. Seven grams of the drug had been given. This was immediately discontinued. Her temperature began to rise two days after the drug had been stopped, and her condition again became critical. She was transfused and given two grams more of the drug. Her white blood count a few hours before death was 5,650, 92/8. We felt that this patient might have recovered if the sulfapyridine therapy had not been discontinued. This patient was one of the first in the series.

Case II. W.W., Male aged 71, had been discharged as a case of coronary sclerosis with angina pectoris four days before his readmission. He had a right lobar pneumonia (Type III). His WBC was 15,450, 80/20 on admission. Treatment with the drug was not started until two days after admission because of deferred diagnosis. One day after treatment his count fell to 1,450. He improved a little but his count began to rise the next day and was 12,800, 80/20 before death on the following day.

Comment

The mortality rate of 35% (1934-1938) was that for all ages. It is significant that in patients under the age of 60, the rate was 20.4%, rising to 60.3% in those over 60. The mortality in patients with co-existing disease was two and one-half times greater than in the complication free group.

According to Bullowa[1] in a study of 1129 adult cases of pneumonia, non-serum treated, the mortality rate was 26.9%. Among adults types I, III, II, V, VIII, VII, and IV (in the order mentioned) account for most pneumonias. Type I was present in approximately one quarter of all his cases. The highest mortality percentage was found in Type II (44.8%) and Type III (41.1%). These types had the highest frequency of blood invasion. In cases with blood stream infection the highest mortality was found in Type III (96.7%).

Plummer and Ensworth[2] report a 5.6% mortality in 36 cases of type III pneumonia (treated with sulfapyridine and serum).

Although the mortality rate for the glucose treated cases in our series was higher than those routinely treated, intravenous glucose therapy has its place in the treatment of individual indications in the modern treatment of pneumonia.

The average age of all patients who died in the 1934 to 1938 period was 49.3 years. In the sulfapyridine series it was 52.3 years. In view of the fact that almost 50% of the patients in the latter group were over sixty years of age, the sulfapyridine mortality of 8.3% (excluding 24 hour deaths) is startling as compared with the revised mortality of 30.2% for the routine, glucose, and serum cases (1934 — 1938).

Agranat et al[3] report a mortality rate of 7.4% in the treated and 22 2% in the control group. They noted that a secondary pyrexia was quite common. In their series, vomiting and diarrhea occurred in 15 to 20% of the treated cases. Four patients with a secondary pyrexia were found in our group. There was no case of hematuria or diarrhea Two of our patients had moderate cyanosis; three were nauseated; one vomited twice; and one had a facial erythema which lasted 48 hours.

Agranat et al[3] state that in most of the sulfapyridine treated cases, the leucocytosis accompanying the infection appeared to be practically undisturbed by the drug. Our findings do not support this view nor that of McIntosh and Whitby[4]. They found "that rabbits fed with M & B 693 over a period of four days show no changes in leucocyte count. The drug, therefore, does not act as simple leucocyte stimulant. Mice inoculated with living pneumococci become leucopoenic if the infecting dose is sufficient to produce symptoms of illness. If the dose is so small that no illness is produced, leucocytes remain at the normal level. The same features can be observed in mice or rabbits inoculated with large doses of pneumococci and protected with M & B 693. Those animals which survive have normal leucocyte counts, whereas animals which the drug fails to protect have a leucopenia. But if recovery occurs without the aid of M & B 693 a leucocytosis is observed. In mice and rabbits therefore exhibition of the drug is not associated with stimulation of leucocytes. The blood picture is an inert one which implies neither stimulation nor depression of the marrow."

Our findings in this small series, indicate that there is a definite leucocytic response to sulfapyridine. In the majority of cases that recovered there was produced a relative leucopenia in 24 to 48 hours. We felt that the absence of a leucopenic response made for a poor prognosis.

Observation of the two patients whose case histories were presented above, lead to the conclusion that a marked leucopenia with normal differential count is no contraindication to the further administration of sulfapyridine.

The studies of the sulfapyridine concentration in the blood indicate that good prognosis does not go hand in hand with high concentration.

In the entire series, the average number of days of illness before admission in the recovered and expired cases was practically the same. The sulfapyridine treated cases were temperature free in 1.6 days; the 1934-1938 group in 9.4 days.

The mortality rate of 17.6% in the serum treated group bears out the accepted experience that serum treatment cuts routine treatment mortality in half.

The pneumonia mortality (1934-1939, inclusive) in Hartford, Connecticut, for February, March and April was furnished through the courtesy of James F. Donahue, Director of the Bureau of Vital Statistics. The rate per 100,000 population was as follows: 1934 (137.3) 1935 (119.2); 1936 (162.3); 1937 (118); 1938 (63.4); 1939 (94.1). The lowered rate in the last two years can be explained on the basis of more wide spread and more intelligent use of serum therapy and also the advent of sulfapyridine.

The comparative results of treatment in consecutive years on the same service in our series of cases demonstrates that no patient with pneumonia should be deprived of the unquestionable aid of sulfapyridine or serum therapy.

Summary and Conclusions

1. One hundred and sixty-five cases of pneumonia were treated on one medical service using routine, concentrated glucose, serum, or sulfapyridine therapy.

2. Unrevised and revised mortality tables are discussed for years 1934 to 1939 inclusive. The revised mortality rate for all cases treated

without sulfapyridine was 30.2%; with sulfapyridine, 8.3%.

3. Patients with co-existing disease had a two and one half times greater mortality rate than those without complications.

4. In the pre-sulfapyridine group the mortality rate for all patients below sixty was 20.4%; above sixty the rate was 60.3%.

5. The mortality in the intravenous glucose treated cases was slightly higher than in those treated routinely.

6. The average age of all patients who died in the 1934 to 1938 period was 49.3 years. In the sulfapyridine series it was 52.3 years. Almost 50% of the patients in the latter group were over sixty years of age which makes the revised mortality of 8.3% more striking.

7. An average of 1.6 days elapsed before the temperature fell to normal and remained there in the sulfapyridine group; whereas, 9.4 days passed before the temperature remained normal in 1934 to 1938 group.

8. In contradistinction to previous findings in the literature, the majority of sulfapyridine treated cases showed a definite leucocytic response to the administration of the drug. A relative leucopenia was observed following treatment in most patients who recovered.

9. The results in a study of 165 consecutive cases of pneumonia indicate clearly that no patients should be deprived of the unmistakeable advantages of serum or sulfapyridine therapy.

BIBLIOGRAPHY

1. Bullova, Jesse G.M., M.D. and Gleich, Morris; Amer. Jour. Med. Sciences Vol. 196. July to December, 1938, Pages 709-715..

2. Plummer, Norman and Ensworth, Herbert; Bull. N.Y. Acad. of Med., April, 1939.

3. Agranat, A.L., M.D., and Dreosoti, A.O., M.D. and Ordman, D., B.A. M.B.; No. VI, Vol. I, 1939, February 11. Pages 309-317

4. McIntosh, James, M.D. and Whitby, Lionel E. H., M.D.; No. VIII, Vol. I, Feb. 25, 1939 Page 431.

SOUND SLIDEFILM AVAILABLE CONCERNING PREVENTION OF INDUSTRIAL EYE ACCIDENTS

How eye accidents are prevented in industry, through education of workmen and the use of goggles, masks and other protective equipment, is dramatically portrayed in "The Eyes Have It", a new sound slidefilm sponsored by the National Society for the Prevention of Blindness.

Combining humor with a serious presentation of the factors responsible for eye accidents in industrial plants, this educational film is intended for groups of workmen and foremen as well as safety directors. It was produced and directed by Harry Guilbert, a member of the Industrial Advisory Committee of the National Society for the Prevention of Blindness. Mr. Guilbert is Director of the Bureau of Safety and Compensation for the Pullman Company.

The tragedy of blindness resulting from carelessness is contrasted with the absence of eye injuries where hazards are recognized and a continuous safety campaign is conducted. The importance of the problem, which is presented graphically and simply in this film, may be judged from these facts:

There are in the United States today close to 8,000 persons who have been blinded by the eye hazards of industrial occupations and more than 80,000 persons who have lost the sight of one eye as a result of these hazards. To this total there are added each year at least 75 persons who lose the sight of both eyes and 2,000 persons who lose the sight of one eye because of industrial or occupational hazards. The number of men and women in industry who lose permanently part of the vision of one or both eyes undoubtedly runs into tens of thousands each year.

Inquiries concerning the film should be addressed to the National Society for the Prevention of Blindness, 50 West 50th Street, New York City.

THOUSANDS HAVE SAID

"Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2)

Fundamental Principles of Treatment of Gonococcal Infections of Women

ROBERT M. LEWIS, M.D.,
New Haven, Conn.

1. The majority of gonococcal infections of urethra and cervix seen in practice will recover in six months more or less without tubal infection if judiciously handled and allowed to do so.
2. Injudicious local treatments can and often do spread the infection to the tubes.
3. Abstinence from alcohol, sexual excitement of every sort, and avoidance of violent exercise (particularly about the time of menstruation) are essential.
4. There is no evidence that local applications or treatments applied to the vagina or the cervix are curative. Vaginal douches, topical applications to the cervix, and cauterization of the cervix are *not* curative procedures while the gonococcal infection persists. Local applications of heat may relieve symptoms, but are never curative and are unnecessary (this includes diathermy). There is always danger that such treatments may cause tubal infection.

The vaginal approach is useful only (a) to help establish a diagnosis or observe the result of treatment by noting the amount and type of cervical discharge and the appearance of the cervix, (b) to take spreads and swabs for culture from the cervical canal, and (c) to satisfy the patient. Cauterization is used to advantage in treating secondary infection of the cervix only after the gonococcal infection has been eradicated. In some long persistent cases of gonococcal endocervical infection it is necessary to "cone out" the cervix to eliminate the area of infection.

Diagnosis by spreads alone, even in expert hands, is notoriously inaccurate. Positive cultures are of enormous value, especially after the acute phase has subsided. Single negative spreads and cultures have no significance. Swabs must be taken with technical care to obtain positive cultures or spreads. Use no lubricant on speculum.

A. Cleanse cervical os and remove mucus plug with sterile cotton. Insert cotton swab well into cervical canal. Cultures must be made on plates before swabs dry or gonococci will not grow.
B. When taking spreads or cultures from the urethra be sure patient has not urinated recently. Massage urethra downward with forefinger. Insert swab well into urethral canal after cleansing external meatus.
C. Express contents of Bartholin's glands by "milking" for spreads and cultures.

At times diagnosis must depend on clinical findings alone when spreads and cultures are negative. If such are fortified by history of intercourse with an infected partner, for instance, treatment may be indicated in spite of negative laboratory findings.

Treatment

The only curative methods at our disposal in cases of acute or subacute gonorrheal endocervicitis are: (1) use of sulphonamides in adequate amounts, (2) artificial fever, which can only be carried out satisfactorily and safely in a few institutions with large and well-trained staffs.

Sulphonamides

Inadequate dosage is not curative but masks the infection, reducing discharge and rendering "spreads" as well as cultures negative. Even if not hospitalized, dosage should be adequate and patient must be seen at least every 48 hours.

Example of Adequate Therapy Sulfapyridine.

Sulfathiazole or sulfapyridine are far more effective and less toxic in adequate dosage than is sulfanilamide. Adequate dosage (J. F.

Mahoney and C. J. Van Slyke) consists in giving sulfapyridine or sulfathiazole, 1 tablet, Gms. 0.5 (grains 7½%) every four hours at 8 A.M., 12 M., 4 P.M., and 8 P.M. (daily total amount Gms. 2.0) for 12 days and no longer. Such doses very rarely cause toxic symptoms and give excellent curative results. Sulfathiazole given in same way is probably preferable to sulfapyridine and is practically non-toxic and equally effective. Acute gonococcal salpingitis requires bed and often hospital treatment. Administration of sulfathiazole or sulfapyridine as described above is remarkably successful. Fever, pain, and tenderness almost, or entirely, disappear in from 48 hours to 96 hours in nearly all cases.

If patient is not improved after five days' administration of sulfathiazole or cured after 12 days, change to sulfapyridine and treat with same dosage 12 days. (Reverse procedure if sulfapyridine is first used). Limitation of fluids is unnecessary. Toxic symptoms which indicate stopping treatment: 1. fever, 2. severe gastro-intestinal disturbance, 3. hemolytic anemia or agranulocytosis, and 4. drug rash.

In our own experience sulfathiazole is far less toxic and yields better results in the treatment of gonococcal infections than does even sulfapyridine. There is every reason to believe that given as here recommended one may expect cures in more than 80% of one's cases.

Other than slight headaches, slight nausea or malaise we have had no evidences of toxicity. We have seen no renal disturbances nor crises of anemia. Patients with hemaglobin of less than 50% or a proportionally low red blood cell count should not be given sulfapyridine or sulfathiazole.

When sulfapyridine or sulfathiazole are given in the doses here recommended there appears to be no need of carrying out blood concentration tests for other than investigative work. The concentration with these doses appears to be sufficient for clinical results.

The value of sulfathiazole in treating gonococcal infections is fairly comparable to its recognized worth in the treatment of the pneumonias.

Criteria of Cure

1. No patient should be discharged as cured until 4 months of negative spreads and cultures, etc., taken every two weeks, have been obtained. Must also be "clinically cured".
2. Do not forget that an infected husband or consort will reinfect the patient unless also treated.
   Every patient must have a Wasserman Test.

Gonococcal Vaginitis of Children

Investigations of New York Study Group (A. Cohn et al) show that about 75% of such cases recover spontaneously if untreated in six months or less. Estrogenic treatments give apparent good clinical results with negative spreads, BUT cultures remain positive as long as in untreated cases.

Best Treatment. Sulfapyridine (or sulfathiazole) given in daily total doses of Gr. ½ per pound of body weight will probably cure 90% of such cases if continued for 7-12 days. Four doses should be given at four hour intervals daily. Total daily dose should not exceed Grams 2. Children tolerate this well.

☆☆

FULL TERM PREGNANCY IN BROAD LIGAMENT

Doctors Beal and Cassell in India report in the Journal of the Iowa State Medical Society (Vol. xxx, No. 9, Sept. 1940) an interesting case of full term pregnancy in the broad ligament.

This forty or forty-five year old coolie patient had had four normal pregnancies, the last about twenty years before this one. During this pregnancy there had been considerable abdominal pain for six months before delivery.

Laparotomy under chloroform anesthesia revealed a full term, seven pound foetus in the left broad ligament, the ligament being stretched over the child and the uterus pushed to the right. On removing the child the left foot was found to have pierced the broad ligament posteriorly and it therefore was dissected out from the bands of muscle of the broad ligament. The constriction had resulted in a deformity of this foot. The placenta was very irregular and was removed with considerable difficulty from the inner surface of the broad ligament. The baby gave a few gasps and then died. Resuscitation was unsuccessful The patient made a slow but uneventful convalescence.

Problems Relating to Diphtheria Toxoid Immunization*

M. M. HILLMAN M.D.,
New Haven, Conn.†

It is universally accepted that toxoid is the most practical immunizing agent in diphtheria immunization and that the Schick test is the approved means by which we can determine whether an individual is immune as a result of injection of toxoid or has natural immunity.

Problems have developed in connection with diphtheria toxoid immunization which are of practical interest both from the administrative view point and from the experience of the physician in private practice. In the hope that some of these may be solved, a study was undertaken at the suggestion of Doctor Joseph I. Linde. The problems considered are as follows:

1. Age factor in relation to immunity.
2. Time relationship between immunization and Schick test reaction.
3. Problems of reversal from a Schick negative to a Schick positive reaction.
4. Effect of injection of two doses of toxoid in comparison with three.

The first problem to be considered is the age factor in relation to immunity. This study indicates as shown in Table I that there is a higher percentage of negatives in a group of children immunized between six months and nine months of age than when immunized at one year of age using the same technique for both groups. The high percentage of negative reactions is probably not due to the immunity conferred as a result of toxoid administration, but is influenced by the passive immunity inherited from the mother. This confirms the results of studies made by other investigators. While toxoid immunization against diphtheria will add protection to a larger percentage of children if performed at a later age after the passive immunity derived from the mother is gone, this is no indication against immunization before nine months of age, when a Public Health program is considered. But children must be Schick tested after immunization and again re-Schick tested at a later period of time if we are to be certain of results in individual cases. Immunization at a later age is more applicable where the private practitioner is concerned, because the child is under closer observation and because there are other preventive measures which he institutes at six months of age, such as, whooping cough inocculation and vaccination against smallpox.

2. As regards time relationship between immunization and Schick test reaction, it was shown as indicated in Table II that the percentage of negative reaction is considerably smaller when infants are Schick tested one year after immunization than when Schick tested six months after immunization. In other words, there is a decline in the ability to give a negative reaction as the time interval between the last dose of toxoid and the Schick test is prolonged. It would seem, therefore, that it would be a safe and wise procedure to Schick test children one year after immunization instead of six months. In this manner, a better gauge may be obtained as to the degree of immunity conferred. It would also appear that re-Schick testing at definite intervals is a good procedure.

3. Concerning the problem of reversal from Schick negative to the Schick positive, this study has shown as indicated in Table III that there is a 25.5% reversal when children are immunized with two dose toxoid. It is also indicated that the highest percentage of reversals appears to be in children who were immunized between six months and nine months of age, and of those children who became positive, 70% occurred between two and four years after immunization. This suggest

---

*Presented at the 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

†From the Department of Health, New Haven.

TABLE 1 — Reactions to Schick Tests, New Haven

Age Toxoid	*Males*		*Females*		*Both Sexes*	
Given.	Total	% neg.	Total	% neg.	Total	% neg.
6-8 mos.	308	88.0	268	82.8	576	85.6
9-11 mos.	131	80.1	142	72.5	273	76.1
12 mos.	53	75.5	55	74.5	108	75.0
TOTAL	592	84.5	465	78.7	957	81.7

TABLE II — Time interval between Immunization and Schick test.

Age Toxoid	4-6 *mos.*		7-11 *mos.*		1-1.9 *yrs.*		2 *yrs. and over*	
Given.	Total	% neg.	Total	% neg.	Total	% neg.	Total	% neg.
6-8 mos.	95	93.7	304	88.5	133	79.7	44	65.9
9-11 mos.	26	92.3	114	80.7	94	78.7	89	46.1
12 mos.	17	88.2	33	95.8	37	78.4	21	57.1
TOTAL	138	92.8	451	85.6	204	79.2	104	56.7

TABLE III. — Data concerning 180 Schick negative children who had been re-Schick tested from one to five years after immunization.

Age at time of	*Total*	*% Positive*	
Immunization	*Neg.*	*Pos.*	*% Pos.*
6 months	21	10	32.7
7-8 mos.	9	8	47.0
9-11 mos.	7	4	36.4
1-1.9 yrs.	13	3	13.1
2-2.9 yrs.	6	2	25.0
3-4.9 yrs.	19	1	5.0
5 yrs. and over	59	18	23.3
TOTAL	134	46	25.5

the desirability of re-Schick testing all children before they enter school.

4. Regarding the effectiveness of the two dose toxoid in comparison with the three dose toxoid this study has shown that the percentage of negatives is much smaller when two doses are administered than when three doses are given. Thus our analysis shows that when two doses are administered, the percentage of Schick negatives is 81.7% while when three doses are administered, the percentage is about 96% as shown by Benjamin et al. We have also shown here that one dose of alum precipitate toxoid is more effective than two doses of liquid toxoid. It would seem, therefore, that three doses of unmodified toxoid given at four weeks interval is the most effective method of diphtheria immunization.

5. As to Schick testing after immunization, while it may not be good economy in larger cities, the results of our investigations indicates that the Schick test after immunization in communities like New Haven is a necessary procedure, both for the private practitioner and the Public Health Administrator.

BLOOD PRESSURE? PRESTO!

You are always asking, "What's new?" The Taylor Instrument Co. answer with their introduction of a manometer cuff based on an entirely new time saving principle. Fits instantly all sizes of arms without twisting or slipping. For sale by The Professional Equipment Company. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

(SEE PAGE 2)

The Treatment of Compound Fractures*

DANIEL C. PATTERSON, M.D.,
Bridgeport, Conn.

As a prophylactic measure all efforts toward accident prevention should be encouraged, and I feel that in every school in the land the first five minutes after the opening bell could well be devoted to talks and demonstrations towards this object. In time, self preservation might become second nature.

All efforts towards the efficient treatment of accident victims should likewise be encouraged, and the instruction of volunteer First Aid men, with proper fixation splints at their disposal, is a step in the right direction.

Compound fractures are simple fractures with a skin wound, and present to the doctor the additional factor of treating the surface wound as well as the fractured bone. There may be much less trauma to the soft parts in a compound fracture than in a simple one, and the treatment will in some cases be very easy, but there is always the much greater danger of infection, and it is still this factor that calls for expert judgment and technique on the part of the doctor.

The process of healing of a fracture is the same whether it be simple or compound, and that is by the formation of callus, due to a deposit of calcium in the exudate thrown about the fractured ends. The same soft tissue damage may be present in both simple and compound fractures, but it is not hard to visualize the havoc that could be wrought by sepsis in the newly forming bone. It is therefore a matter of prime importance to prevent infection.

Treatment should start at the place of accident, for it is there that the good or bad result may be determined, and close attention must be given to this first aid or emergency treatment. A careful inspection and examination will reveal the extent of the injury as far as the compound wound is concerned.

Do not move the patient unless absolutely necessary to get him out of danger, until the injured part has been immobilized. Cut the clothes away from the injured limb, do not try to remove them. Inspect the fractured part and first see if bleeding is present. If it is, control it. Apply a tourniquet until a clamp or ligature can be put on. It is surprising at times the small amount of hemorrhage that is present in crushing injuries. Cleanse the wound at once if facilities are at hand for doing so; if not cover the wound with a sterile, antiseptic or clean dressing.

The next step in the local treatment is to get the injured parts gently in proper position and immobilize them as well as possible for transportation of the patient to a hospital. This immobilization can be accomplished by means of standard or improvised splints. Specific directions cannot be given as conditions vary, but a doctor should be prepared for these emergencies and be able to make splints out of anything at hand.

Transport the patient as carefully as possible, face down if the injury is to his spine, and on a firm support if the injury is to his thigh.

As a matter of practice, there is little that can be done for the patient's general condition at the scene of the accident. A dose of morphine may allay his suffering, and blankets will keep him warm. The active treatment of shock, if present, generally starts on his arrival at the hospital or his home. One must quickly look for injuries to internal organs that may be present with the perfectly evident fractured limb. I will merely mention injury to the central nervous system, lungs, liver, spleen, kidneys, gall and urinary bladders, and the intestinal tract.

It is needless to point out that most of these injuries demand early attention, and should be recognized or suspected on first examination and appropriate measures for care instituted.

---

*Read at the 15th Clinical Congress, Connecticut State Medical Society, Sept. 19-21, 1939.

The treatment of shock, if present, should be the first consideration of the doctor, for that is the factor of greatest danger. The control of hemorrhage gentle handling, morphine for pain, and covering for warmth — is generally all that can be done for the patient in the field. After arrival at the hospital proper treatment should be instituted at once. Features of treatment are: rest, with elevation of the foot of the bed; heat by external means; infusions of saline or glucose; blood transfusions if hemorrhage is a factor; and necessary drug stimulation. I have found caffein sodium benzoate in ½ to 1 c.c. doses a valuable agent, but stimulating and vaso constricting drugs have only a temporary value, dependence must be placed on increasing the blood volume, preferably by transfusions of blood.

As early as possible prophylactic doses of tetanus and gas bacillus antitoxin should be administered, and in some cases their use should be repeated weekly for several weeks. There are no rules that I know of that will help you to select the repeaters. I have seen fatal tetanus develop a month after the injury in spite of the use of 1500 units of T.A.T.

The use of tetanus antitoxin has received a great deal of attention lately and justifiably so. The disagreeable and dangerous reactions that sometimes follow its administration have been responsible for this interest. The reactions are due to horse serum and will occur in certain individuals. Tests for sensitivity are not reliable for some investigators have pointed out that reactions will occur in some patients who do not respond to the test, and they add, "positive tests should not be considered conclusive, and thus prevent the use of anti toxin in a case where it may be life saving." From all the information I could gather, desensitization is impossible. If the test is positive, the anti toxin should be given very slowly, and it is recommended that five to fifteen minims of a 1-1000 solution of adrenalin be given 6 to 8 minutes before the first injection.

There is no way at present that serum reactions can be prevented, and horse serum is still most generally used.

The cases of acute anaphylaxis occur in patients who have previously had horse serum injections. These are very alarming, as some of you know, the symptoms coming on in from a few minutes to an hour or two, One should try to find out whether or not the patient has previously had any serum injections, so as to prevent if possible this catastrophe. In the way of treatment, a tourniquet above the point of injection should be applied, and then adrenalin and sedatives administered. At present there is no test to determine immunity from tetanus comparable to the Schick test for diphtheria. Patients dangerously sensitive cannot be safely injected with horse serum by any known method.

Active immunization against tetanus has been the objective of considerable work in the past few years. Its principle advantages would be a certain amount of protection against tetanus infection, and absence of serum reactions.

Active immunization has not been perfected as yet and the duration of immunizations is unknown. However, tetanus toxoid is known to confer an active immunity to some extent and will give greater security in cases of injury with a potential tetanus exposure, and will eliminate the reactions that occur with the serum injections.

To obtain active immunization, two injections of the toxoid are given six to eight weeks apart; as there is no immunity present until after the second dose, it is of no value in a fresh injury or where the patient has only had one dose of toxoid. In such a case protection must be sought with tetanus antitoxin.

In the case of a patient who has been immunized with toxoid, it is advisable to give an additional injection of toxoid, following an injury susceptible to infection.

It would seem that all persons working about horses or on farms should have the protection of active immunization against tetanus. Reactions with slight fever and urticaria have occurred after toxoid injections, but they have been very mild.

We now have our patient in the hospital. His wound has a First Aid dressing on. His fractured limb is splinted; his shock has been treated; he has had antitetanus and gas serum, and has been examined to determine the extent of injuries.

An x-ray examination to determine the extent of the fracture and the position of the fragments now should be made. While a good many fractures were treated quite successfully before the use of x-rays, its aid should always be enlisted when available. Fleuroscopy cannot take the place of good radiographs. The use of a portable machine may save the patient the discomfort of being moved about.

In the matter of anesthia, I am in favor of spinal, ether, and intravenous sodium pentothal, with avertin in certain cases. I know that much can be and has been said in favor of newer agents, with some special but not great advantages, but until one can be assured that there is no danger of an explosion I can see no justifiable reason for using them, to the exclusion of older and more tried agents.

Operative Procedure

In cleansing the skin and the wound itself I have for some time relied entirely on green soap and water, with saline as a final wash, and the results have been most satisfactory, much better than when we used antiseptics. By this method the wound is covered with gauze and the surrounding surface scrubbed. The wound is then cleansed with the soap, using gauze to do so. Gross foreign matter is removed, of course. After this cleansing has been done the wound and adjacent area is flushed with saline. Obviously, the surgeon's gloves, gown, and any instruments used should now be discarded for clean ones.

If the wound in the skin is just a small puncture made probably by the pointed fragments of bone, I think it should be left alone after cleansing. If the edges of the wound are ragged or traumatized they should be cut away and the skin left unsutured. I do not believe that incising such wounds and doing deeper debridement will improve the results. Someone with more experience in such cases may feel differently about it.

In large wounds, traumatized skin, devitalized muscles and loose bone fragments should be carefully removed. Muscle that is devitalized has a dull, pale appearance. It does not bleed when cut and does not retract when pinched with forceps. All muscles showing these characteristics should be cut away by sharp dissection. Hemostasis is attended to, and severed nerves or tendons are sutured with care. During the operation of debridement the limb should be kept as quiet as possible.

The question of whether or not it would be advisable to plate the fragments will arise in a few cases. Good apposition is necessary for good union, and if apposition cannot be maintained without internal fixation of some type, then it should be done. Careful technique will give a high percentage of good results.

The wound can be closed with sutures, so-called primary suturing, or it can be left open and covered with gauze soaked with Dakin's solution. This is kept applied to the wound for several days, and then if infection is absent, so called secondary suturing is carried out. This is a method that should be used if operating conditions are not ideal.

Following the debridement and closure or packing of the wound, the application of fixation and traction apparatus should follow the same principles as in simple fractures, and once the external wound is well healed it will require no more additional attention than a simple fracture except that delayed infection should be watched for.

If gas bacillus infection occurs, prompt treatment may save the patients limb as well as his life. The question will arise whether or not to amputate. The decision must be based on the patient's condition, the local damage, and the usefulness of the limb even if saved. I have seen patients with saved limbs that were liabilities rather than assets. The patient's life should not be jeopardized to save a limb.

Wide open incisions or amputations, specific serum therapy, and blood transfusions are the standard aids at present in treating sepsis. Some men have reported excellent results with treatment by radiation. Of course sulfanilamide has its place. In Surgery for July, N. K. Jensen and co-workers at Univ. of Minn. Medical School report the use of crystaline sulfanilamide in 5 to 15 gm. doses directly into the wound, following thorough cleansing and debridement. They reported 41 cases of compound fractures treated by this method had healed without any infection. 94 open fractures treated by similar methods, but without benefit of sulfanilamide, showed 27% infection, including 7 cases of gas gangrene and 5 amputations.

Other complications to be mentioned are embolus, phlebitis, osteomylitis, as well as post anesthesia pulmonary complications, but these are common to any surgical procedure and this paper is not concerned with their treatment.

To summarize the important factors of treatment I would call attention to the following procedures:

Careful examination of the patient to determine the nature and extent of injury. Remember, as Gorrell has so nicely put it, "For one mistake that is made by not knowing, ten mistakes are made for not looking."

Gentle First Aid treatment with arrest of hemorrhage.

Attention to patient's general condition and splinting of the fractured part before transportation.

The administration of tetanus and gas bacillus antitoxin with repeated doses in some cases.

Immediate attention to shock and internal organ injuries.

Careful and thorough x-ray examinations.

The operative procedure should consist of careful cleansing and debridement of the wound with repair of severed nerves and tendons under anesthesia.

The application of proper fixation and traction apparatus, for fractures should be reduced as early as possible, and if re-examination by the x-ray shows poor alignment and apposition, then the position should be corrected at once. It is needless to point out the advantages of the modern fracture operating tables such as the Hawley table.

The treatment of compound fractures requires experienced surgical judgment and ability, with constant attention to details.

News *from* Yale University School *of* Medicine

The Adjutant General of the United States Army has authorized the organization of The 39th General Hospital to be sponsored by the Yale School of Medicine. President Seymour has announced that the School of Medicine has been commissioned to provide a staff of thirty two physicians, all of whom will receive commissions in the Medical Officers Reserve Corps, and the School of Nursing has been requested to organize a staff of one hundred and twenty Red Cross nurses. The officers for the contemplated 39th General Hospital have been selected but no army appointments have been made, pending physical examinations for those concerned.

The Doctor's Office

Frank T. Oberg, M.D., announces the removal of his office to 50 Farmington Avenue, Hartford.

W. Holbrook Lowell, Jr., M.D., announces the opening of an office for the practice of Internal Medicine at 580 Asylum Street, Hartford.

☆☆☆

Connecticut Hospital Association

(Continued from Vol. IV, No. 10, Page 618, Oct. 1940)

advising us that it is not incompatible with the A.H.A. By-Laws for a proposed change in our State Association regulations permitting the Board of Trustees rather than the State Assembly to investigate and vote on applications for membership.

Secretary was authorized to place the proposition on the agenda for our fall meeting.

Secretary read an invitation from the State Medical Association for a joint meeting to be held on Prepaid Medical Service on September 10, 4:00 P.M. at New Haven. The Secretary was requested to notify the Medical Society of our acceptance.

VOTED: To adjourn. 4.00 P.M.

Attest: William B. Sweeney,
Secretary

Tumors of Lateral Aberrant Thyroid Tissue

Report of Two Cases*

WILLIAM A. GEER, M.D.,
Bridgeport, Conn.

It is the plan of the *Journal* to publish each month one or more interesting cases from the pathological or tumor clinic of some one of the hospitals in the State. The accompanying report represents the first in this series. (Editor).

Tumors of lateral aberrant thyroid origin are uncommon, but not a great rarity. Recently Cohn and Stewart reviewed the literature, and found that 156 cases had been reported. They added 20 cases of their own, and Ward reported 15 cases, thus making the total number of cases 191.

The origin of these tumors can be explained by referring to the embryological studies of Weller, in which it is demonstrated that the human thyroid gland arises from a median and two lateral components, the latter coming from the fourth bronchial pouch of either side. Histological study of thyroid neoplasms also yields evidence that the thyroid gland arises from both lateral and median components; for, as Cohn and Stewart point out, papillary tumors along the tract of the median primordium are extremely rare, while 80 per cent of the lateral aberrant thyroid tumors seen by these authors were papillary in structure. Consequently, it seems reasonable to regard lateral aberrant thyroid tumors as neoplasms of portions of the lateral thyroid component which failed to unite with the body of the gland.

These tumors are usually multiple. They are most often located beneath the sternomastoid muscle, and frequently they are large enough to cause considearble bulging of the side of the neck and deviation of the trachea. In many cases there is an associated tumor in the body of the thyroid gland.

The gross appearance of lateral aberrant thyroid tumors resembles that of metastatic melanoma, for they are dark brown in color. On cross section cystic changes are frequently found. Histologically, the structure is usually a mixture of papillary glandular formations and colloid filled acini. One or the other of these characteristics may predominate, and occasionally a pure adenomatous hyperplasia is seen. The histological appearance of some of these tumors is that of malignancy, but Crile states that metastases do not occur. Local recurrence, however, is not uncommon, and Ward reports one case with lung metastases.

The treatment has usually been surgical excision. Crile believes that x-ray therapy does not improve the prognosis. Ward, on the other hand, favors post-operative irradiation.

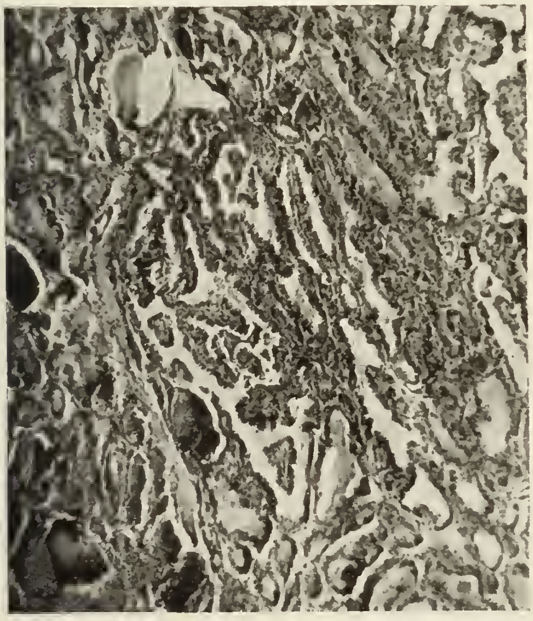
The following two cases were operated on by Dr. I. L. Harshbarger at the Bridgeport Hospital:

1. Mrs. F. T. aet. 49. Patient was a married woman who had noticed a tumor of the left side of the neck for 15 years. For several weeks before admission there had been pain in the left side of the neck and breathing had become difficult. On examination a large movable mass was palpated in the left side of the neck, apparently separate from the thyroid gland, which latter was not palpably enlarged. The trachea and larynx were found to be displaced to the right, a finding which was confirmed by x-ray examination. A biopsy of the mass in the neck done on June 19, 1940 showed what was thought to be thyroid tissue. A diagnosis of carcinoma of the thyroid with neck metastases was made at this time, and deep x-ray therapy to the neck was given. Subsequently the neck tumor decreased in size. While this case was under treatment, case No. 2 was seen, and the diagnosis was changed tentatively from carcinoma of the thyroid to lateral aberrant thyroid tumor. On August 23, 1940 the region beneath the left sternomastoid muscle was exposed at operation. Six adherent tumor masses varying in diameter from 2 to 4 cms. were dissected out. There was no evidence of tumor of the body of the thyroid gland. The tissue removed was brown in color, and showed regions of cystic change. In places there were small patches of calcification. Microscopic examination showed colloid-filled acini and papillary structures, the former predominating. A diagnosis of lateral aberrant thyroid tumor was made. The wound healed slowly, probably because of preoperative irradiation. Following operation there was relief of dyspnea.

---

*From the departments of surgery and pathology of the Bridgeport Hospital.

2. Miss E. B. aet. 15. Patient was a school girl whose only complaint was a swollen gland in the right side of the neck. This had been present for about one year. Examination showed a movable, irregular tumor beneath the right sternomastoid muscle. The thyroid gland was not enlarged to palpation. An x-ray of the chest showed no pathology. On July 2, 1940 a specimen from the tumor in the neck was taken for biopsy. From this biopsy a diagnosis of lateral aberrant thyroid tumor was made. On July 16, 1940 the right side of the neck was surgically explored. Three irregular tumor masses were removed in a block from beneath the right sternomastoid muscle. The tissue removed consisted of an irregular trilobed structure, the largest lobe of which measured 3 x 6 cms. The tissue was brown in color and showed regions of cystic change. Microscopic examination showed a mixture of papillary structures and colloid-filled acini. The diagnosis was lateral aberrant thyroid tumor. The patient made a good recovery from the operation and the wound healed by first intention.



Photomicrograph of specimen from case No. 1 showing colloid-filled acini and papillary structures.

Summary

Two cases of lateral aberrant thyroid tumor are reported. In both cases the tumors were surgically removed.

BIBLIOGRAPHY

Cohn, L. C. and G. Stewart: Tumors of the lateral thyroid component, Arch. Surg. **40**:585, April 1940.

Crile, George Jr.: Papillary tumors of thyroid and lateral aberrant thyroid origin, S.G. and O. **69**:39, July 1939.

Crile, George Jr.: Tumors of lateral aberrant thyroid origin, J. A. M. A. **113**:1094, Sept. 16, 1939.

Ward, R.: Relation of tumors of lateral aberrant thyroid tissue to malignant disease of the thyroid gland, Arch. Surg. **40**:606, April 1940.

Weller, G. L.: Development of the thyroid, parathyroid, and thymus glands in man, Publication of the Carnegie Institute of Washington, 1933. Contributions to embryology, No. 141.

☆☆

AN AMENDMENT TO SELECTIVE TRAINING AND SERVICE ACT

The following bill, S. 4396, was introduced in the United States Senate during the present session, read twice and referred to the Committee on Military Affairs where it is now under consideration.

A BILL

To amend the Selective Training and Service Act of 1940.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 4 of the Selective Training and Service Act of 1940 is hereby amended by adding at the end thereof the following new subsection:

"(c) Any man selected for training and service under this Act (1) who has been awarded a degree of doctor of medicine or doctor of dental surgery by a recognized medical or dental school, (2) who holds a valid license to practice medicine, surgery, or dentistry in any State, Territory, or possession of the United States, or the District of Columbia, and is engaged in such practice at the time of his selection, and (3) whose physical and mental fitness for such training and service has been satisfactorily determined, shall, in lieu of induction into the land or naval forces of the United States for such training and service, be commissioned as an officer in the Medical Department Reserve Officers' Reserve Corps, and ordered into the active military service of the United States as provided in the joint resolution approved August 27, 1940."

Sec. 2. Subsection (d) of section 5 of such Act is hereby amended by adding at the end thereof the following new sentences: "Medical and dental students at recognized medical and dental schools, and internes and resident phy-

(*Concluded on Page 681*)

State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

What the Family Physician May Expect from the Public Health Nurse

HAZEL V. DUDLEY, R.N.,*
Hartford, Conn.

In carrying on his unceasing war against disease and death as well as in his efforts to improve the health status of the families who have placed themselves under his care, the family physician looks to the public health nurse for assistance. In addition to caring for the sick, the public health nurse works for the prevention of sickness and for health — physical, social and emotional health — of those under her care. Throughout her program she works in cooperation with and under the guidance of the family physician.

Gives and Teaches Care of the Sick

To his patients in the home, the public health nurse gives the same skillful bedside care with as careful attention to the details of treatment and accurate interpretation of his orders as in the best hospitals. In addition to nursing care of the sick, the family physician may look to the public health nurse to teach families many helpful things about the care of the patient. To the wife of a diabetic, or the patient himself, she teaches the technique of administering a hypodermic injection. She helps this patient to grasp the importance of an hygienic regime and his wife how to prepare his diet attractively and accurately. To the devoted but untrained daughter of a bedridden mother, she shows the technique of bathing a bed patient and measures to prevent pressure sores. To the mother who insists on keeping her child with scarlet fever at home, she demonstrates methods of isolation so that others in the family as well as the community may be protected. She assists with the nursing treatments ordered by the physician. She interprets to the mother the wisdom of bed rest and the relationship of medical care to the control of complications and ultimate recovery.

Maternity Care and Supervision

Public health nurses urge prenatal patients to report to their family physician early and regularly. If the physician wishes, the nurse checks blood pressure and urinalysis at the patient's home and sends him the report. Quiet discussions in the patient's home tend to bring to light and dispel some of the patient's fears and ignorance regarding her condition. The nurse encourages the patient to follow the program which the physician has advised and assists her in planning menus to include the prescribed diet. The nurse guides the patient to prepare early the supplies which will aid the physician during her delivery in the home. In many communities the physician may depend on the public health nurse for professional assistance during home deliveries.

Nursing care is given post partum mother and baby and the home attendant is taught safe procedures to be followed between the nurse's visits. Contacts with the mother at this time provide an opportunity to stress methods of handling the infant which foster good health and desirable behavior habits.

Child Health Supervision

Whether delivered in the hospital or at home the public health nurse demonstrates to the mother a simple well organized baby's bath. She emphasizes the superiority of maternal milk and explains factors influencing an adequate supply. If the physician orders a formula, he may expect the nurse to show the mother how to sterilize the equipment and make the formula.

---

*Director, Bureau of Public Health Nursing, Conn. State Dept. of Health.

The public health nurse urges the parents of every infant and child to place them under regular medical supervision. After learning from the physician what he wishes for each child, she explains his recommendations to the parents and assists them to find ways to carry them out. In homes of low economic level the nurse is often helpful with practical suggestions on making the best use of the income. When indicated, she refers families in need to the appropriate agencies.

She urges immunization against diphtheria and small-pox vaccination before the first year and urges parents to consult their physicians also about similar protection against other diseases. Throughout her contacts with parents of young children the public health nurse advises hygienic care and the development of a good health and behavior habits.

Family Health Supervision and Case Finding

Though her original contact with a family may be to give care or advice to one individual, the public health nurse is concerned with the health of the entire family. She promptly refers any member of the family observed to have a symptom of illness to his family physician for diagnosis and treatment. Cases of cancer and tuberculosis have been discovered through such alertness of a public health nurse. The nurse stands ready to assist the physician in whatever way she can to bring such conditions under control. It may be to encourage a syphilitic to continue treatment or to explain to a tuberculosis contact the need for examination or to help a mother with early cancer arrange to leave her home for an operation.

Preparation of Public Health Nurse

In order to do a good piece of work in public health nursing it is essential that a nurse be prepared for this work. Hospital training prepares a nurse for bedside nursing. There are college courses in public health nursing which equip the nurse with public health methods and the health knowledge needed to carry on an adequate program of public health nursing. The larger public health nursing associations have qualified supervisors who guide the inexperienced nurse in her work. Several years ago the Public Health Council of Connecticut recommended as minimum qualifications that nurses who work without the guidance of a qualified supervisor should have, in addition to their hospital training,

> "1. A program of study in public health nursing meeting the National Organization for Public Health Nursing requirements and covering at least one academic year.
>
> 2. Two years experience under qualified nursing supervision in a public health nursing service in which family health is emphasized."

A qualified public health nurse gives the most adequate service.

Need for Medical Advisory Committee

Every public health nursing association needs support and help of the medical profession. Medical Advisory Committees have been found to be indispensable. Such committees representing the medical profession of the community, review the practices and policies of the nursing associations from the medical point of view.

Standing orders for the nurses' procedure on first visits and in emergencies, approved and signed by a Medical Advisory Committee, guide and protect the nurses. Medical Advisory Committees provide opportunity for the medical group to learn more of the work of the nursing associations and for expression of opinion and advice regarding them.

Summary

Throughout his program the family physician finds need for and ready aid from the public health nurse. Physicians can effect the quality of service provided by encouraging associations, when selecting public health nurses, to be guided by the standards approved by the Connecticut Public Health Council. Physicians foster mutual understanding between medical and public health nursing groups by promoting active Medical Advisory Committees.

The
Connecticut State Medical
Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD
Stanley B. Weld, *Editor-in-Chief,* Hartford
Sidney G. Davidson, New Haven
Frank Stafford Jones, Hartford
Charles Mirabile, Hartford
Oliver L. Stringfield, Stamford
Herbert Thoms, New Haven

COUNTY NEWS EDITORS
Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — William M. Joyce, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

STOP AND THINK

Accidents will happen on the best regulated highways.[*]

When a surgeon called to his hospital to treat an emergency is confronted with a patient moribund from shock, with ribs pushed into the lung and bones of a broken extremity out in the world, or milling around in the muscles, and blood vessels like cracked ice in a bag, he is depressed. Why not? Is it fair to allow this superhuman load to be piled upon him? Is it not time that every member of our profession should awaken to aggressive activity toward better care of the patient from the scene of accident to the hospital?

The recent paper by Doctor Clay Ray Murray on "Emergency Handling of Fractures," (reviewed in this issue) was splendid and very timely.

However, the situation is not limited to badly smashed up accidents on the roadside. It includes all phases of first aid to all types of injury sustained in home, athletic field, and factory.

The lay public is becoming conscious of this need as evidenced by the Connecticut Chamber of Commerce, which is about to open an educational campaign to improve first aid instruction throughout our State. In this effort to make Connecticut outstanding in first aid efficiency, it seems evident that the Medical Profession must either lead or follow.

R. M. Y.

---

[*] Connecticut Motor Vehicle Department reports for 1938 17,061 automobile accidents, result of which 11,149 were injured, and 339 killed, in Connecticut.

* * *

WHO HATH DESIRED THE SEA?

Among the profession there are few who truly may be called empire builders. During one of our recent beautiful New England Indian summer days Sir Wilfred Grenfell, known for half a century as the Labrador Doctor, lifted anchor and set out upon his last voyage. At first interested in ministering to the fishermen of the North Sea, Doctor Grenfell in 1892 felt the lure of the Labrador and sailed "down North" to devote the rest of his life to fishermen on this side of the Atlantic

Always sacrificing self, the story of Doctor Grenfell's accomplishments for his beloved Labrador has no equal. He owned and operated schooners which carried him up and down the forbidding coast. In addition to the demands upon him medically he found time to establish schools, industrial centers and agricultural stations, orphanages and cooperative stores. Through these innovations he changed the entire mode of living of the people and by his forceful personality he preached the doctrine of practical Christianity.

Born in Parkgate, England in 1865, Wilfred Thomason Grenfell received his education and training at Marlborough "College" and London Hospital and University. Years later he was knighted, and there were bestowed upon him honorary degrees from a number of American and Canadian colleges and universities and medals from many distinguished societies. Through the years of unstinted devotion and unselfish living his influence has been more far reaching than could ever be measured. Imbued with his spirit there gathered around him an ever widening circle of young men and women who were attracted to Labrador by the work of Doctor Grenfell and even more by admiration for the man himself.

* * *

THE USE OF TOBACCO

In the past ten years there has been a marked increase in smoking by all people of both sexes and all ages. Cigarettes are used for the most part with much less cigar smoking than formerly. There are still many men who stick to their pipe smoking. It is common for men and women to consume a pack of twenty a day. Comparative beginners, young women, older women and boys within a few months will use ten cigarettes a day. Very excessive smokers may consume 60-80 cigarettes in twenty-four hours.

There has been extensive advertising and radio sales talks by the tobacco companies to urge on smokers. If the uninformed or inexperienced listened to such programs, they would be led to think, that tobacco never was harmful, and that it was the means of release for nervous tension, restlessness, and many of the complaints of human nature. Each tobacco company tries to out-do every other competitor in its claims. Practically never do such talks cover an unbiased statement of facts of the benefits and harmful effects of tobacco. Smoking quickly becomes a habit which cannot be readily given up. The proofs of this are the lame excuses and failures of those asked to decrease or discontinue smoking for medical reasons. There are not a few who will smoke two or three cigarettes before breakfast, the same number with a meal, and get up once or twice at night to reach for a smoke. Some users are as bad as alcohol or drug addicts in their cravings for the "weed".

Indigestion, simulating the disorder of a peptic ulcer, may be due entirely to immoderate use. Tobacco is especially harmful to those who have any tendency to gastric or duodenal ulcers. Irregularity of the heart, such as premature contractions, tachycardia and even pain may result from tobacco. Shortness of breath and troublesome coughs are frequently a result and promptly cease when tobacco is discontinued. The same is true of hoarseness. Tobacco is admittedly one of the deleterious influences in Buerger's disease. Toxic headaches, fatigue and nervous tension may result from tobacco. Underweight or failure to gain weight in young people are not rare with smoking. Now and then asthma from being where smoke is will occur in non-smokers. A very unpleasant affect of tobacco is an offensive breath which is almost universal with all kinds of smoking, as is some coating of the tongue. Unsightly discoloration of the teeth occurs with excessive use of cigarettes, pipes, or cigars.

Increasingly, physicians and the lay people have been careless in the use of tobacco in their offices, about hospitals, homes, and public places. They have been unmindful of the offensiveness often to non-users and especially to the sick. Our thoughts about tobacco have been wishful, rather than scientific or unprejudiced.

J. A. W.

* * *

PERIODIC HEALTH EXAMINATIONS IN THE PREVENTION OF CANCER

A number of years ago, the Society passed a resolution advocating the annual physical examination as the best means of preserving health and detecting chronic disease. The medical profession is taking upon itself a tremendous responsibility when it stands back of this statement, but it is the opinion of the Society's Tumor Committee that such a responsibility must be assumed. Certainly it is an indisputable fact that cancer cases will continue to be found in the advanced stages if patients persist in waiting for signs and symptoms to appear before they report to their physicians for examination. Patients must be taught that they cannot safely wait for such signs for if they do it is often an indication of the presence of an advanced and not an early cancer, and it also must be taught that the doctor alone is able to find precancerous and early cancerous lesions. It is only by seeing patients at least once a year that these early lesions can be found and eliminated, but at the same time doctors must impress upon their patients that they do not guarantee to prevent all such lesions from developing or even to discover all the lesions that might be present. Unfortunately this is impossible, for many early cancerous lesions, especially when they occur in the internal organs, cannot be detected by the most up-to-date scientific methods or by a thorough physical examination. Notwithstanding these disadvantages, however, a thorough physical examination will reveal enough incipient diseases and enough early cancers to justify the medical profession's advocation of a yearly examination as the best means of preserving health.

There is no doubt that future medical practice will be preventive medicine. Therefore it will be to the glory of Connecticut physicians if they are first to adopt this plan of annual physical examinations and be in the vanguard of the progressive group who will grasp this newer conception of the practice of medicine which in time is bound to become universal. The medical profession should be the instigator of this new type of practice and should not wait for it to be forced upon them by pressure from lay groups.

The necessity of careful lay education in regard to these annual examinations must be reiterated. Only too often patients have submitted themselves to their physicians for routine examination and been given a clean bill of health only to be afflicted within a short period of time with some disease that undoubtedly was present at the time of examination. Such unfortunate experiences will happen less often when the patient is under the care of a competent and a thorough physician, but in spite of all care and scientific knowledge there will still continue to be some unhappy occurrences of this nature, and it must be emphasized again and again that it is impossible for the doctors to guarantee absolute prevention and immunity from all disease by annual physical examinations.

Last February the Tumor Committee began a campaign to establish the annual physical examination as routine practice in the offices of every physician in the state. The plan of this campaign is to contact either personally or by letter every physician in the state, and request their cooperation by establishing in their offices an annual follow-up system for their patients. Up to the present time Waterbury, Meriden and many Hartford physicians have been approached and the great majority of these have either started the system or have indicated their intentions of doing so within the near future. Follow-up cards are supplied free of charge by the Division of Cancer Research of the State Department of Health, and assistance in establishing this system may be obtained by communicating directly with Doctor Charles L. Larkin of Waterbury, chairman of the Tumor Committee.

C. L. L.

⁂

THE STATE OF OUR HEALTH

In contrast to the ruthless destruction of life in other lands, medicine is pleased to note that it has continued to benefit our people at an increasing rate. The report of Stanley Osborn, the State Health Commissioner, for 1938-1939 is a review of splendid progress. A large part of the report is necessarily statistical but the conclusions are good to read.

The infant mortality in Connecticut has been falling for several years and is among the three lowest in the country. The communicable disease record is being steadily lowered. In 1938 the typhoid death rate was 0.3 a record low, as was a rate of 30.6 for tuberculosis. The pneumonia rate showed an astonishing drop to 48.2 from a rate of 62.9 in 1934. Maternal deaths were 2.9 per 1000 living births in 1938 compared with 2.8 in 1937, an all time low. Even the accident death rate was down. For the year covered by the report it was 67.6 per 100,000 in comparison to 71.5, the average for the last five years.

Cancer alone showed a significant increase. The rate was 135.9 per 100,000, the highest on record. Here is an event that every community with an ageing population must face squarely. Connecticut physicians and health officials realize the problem but there is much yet to be done, especially in the earlier recognition of malignancy.

Connecticut is a healthy State. The whole report is one of progress and achievement in which we all take pride. The first credit goes to the State and local health authorities but it is actually the alert, intelligent private practitioner of medicine who has made this record possible.

C. B.

☆☆

DOCTOR ALEXANDER S. BEGG

The Massachusetts Medical Society has lost a faithful and efficient secretary in the sudden death of Alexander Swanson Begg. Although for the past five years Doctor Begg fulfilled the exacting and arduous tasks his office in that Society necessitated, yet he was best known for the part he played in the advancement of medical education. Beginning medical teaching at his alma mater, Drake University, he continued it at Harvard University and at Boston University, having been professor of anatomy at the latter for nineteen years. During the past seventeen years he successfully filled the position of dean of Boston University School of Medicine. As one reads of the accomplishments of Doctor Begg outside of the medical school one is impressed with their scope. His was a quiet, friendly nature, one to whom his colleagues turned for leadership. Such zealous workers in the broad field of medicine leave vacancies difficult to fill. Organized medicine needs more men like Alec Begg.

☆☆

BIRTHDAY

This month marks the birthday of Connecticut's most famous physician and one of the great figures in American medicine. William Beaumont was born in Lebanon, Connecticut on November 21, 1785. He spent his boyhood and youth there and, against his father's wishes, left early in the year 1807 to seek his fortune elsewhere. Legend has it that he set out for an unknown destination with a horse, a sleigh, a barrel of cider and one hundred dollars.

In the spring of 1807 Beaumont was teaching school in Champlain, New York and soon after he commenced the study of medicine by reading books borrowed from Doctor Pomeroy of Burlington. Three years later he was continuing his studies in the office of Doctor Benjamin Chandler of St. Albans, Vermont; he completed his apprenticeship on June 2, 1812 and was given a license to practice by the Medical Society of the 3rd District of Vermont

It was in the Army that William Beaumont was to make his career and complete what Harvey Cushing has called his rendezvous with fame. President Madison commissioned Beaumont a Surgeon's-mate in the 6th Infantry on December 2, 1812, and for a time he combined private practice in Plattsburgh with his Army duties, resigning from the Army when the War of 1812 ended.

On December 4, 1819 Beaumont was again commissioned in the Army as a First Surgeon and was ordered to Fort Mackinac in Michigan. It was there on June 6, 1822 that Alexis St. Martin, the young French trapper, received an abdominal wound from a shot gun, and then commenced one of the strangest and most productive acquaintances in history. St. Martin survived the accident, developed a gastric fistula and lived out a long span of alcoholic years, most of which were spent with Beaumont who nursed and coddled and forgave him in order to have the opportunity to study the processes of gastric digestion.

The results of these studies, *Physiology of Digestion*, were published in book form in 1833 by Edward P. Allen of Plattsburgh and reissued in 1834 by Lilly, Wait and Company, Boston. A second edition was published from Burlington in 1847.

Beaumont was made an honorary member of The Connecticut State Medical Society in 1833 and in May 1834 he returned to Connecticut to confer with Professor Silliman. The State Medical Society was then in session and on May 14 he presented Alexis St. Martin before the meeting of the Society.

William Beaumont died in St. Louis, April 25, 1853.

C. B.

Clinical Congress — 1940 — In Retrospect

MAURICE J. STRAUSS, M.D.
Chairman, Committee on Publicity and Registration

The sixteenth Clinical Congress, probably the most successful of them all, has come and gone.

If one can measure the success of a meeting of this sort, by the comments heard in the lobby in the intervals between lectures, it was a successful meeting. The committee has long been accustomed to hearing such remarks as; "the best ever," or "it must be good when we come back for more." This year, however, the attitude expressed by such remarks seemed to be universal. If one measures the success of a meeting by the attendance at the sessions, this was surely a success for the auditorium was comfortably crowded during all three days. And if the measure of success is to be the total registration, all doubt is dispelled. For this year produced the largest registration the Congress has ever had, for the first time reaching seven hundred.

Several factors probably cooperated to this end. We were favored with perfect weather. The program was an exceptionally well balanced and interesting one. And in addition, the program was planned so that, with the exception of the three special courses and the section meetings in the evenings, the entire meeting was held in one building. To say the program was well balanced and interesting is perhaps an understatement. The list of guest speakers was studded with the names of famous scientists who have the ability to transmit their knowledge to others. It would be tiresome to mention all of them, but certainly among the highlights were Doctor Joslin's very practical talk on Diabetes, and Doctor Blumgart's discussion of the Treatment of Coronary Artery Disease, on Tuesday. On Wednesday, Doctor Soma Weiss' extremely clear exposition of Nephritis called for very favorable comment, as did also the discussion of the Use of Estrogenic Hormones by Doctor Raphael Kurzrok. In addition the presentation of the pathological findings in cardio-renal-vascular disease, by Doctor Winternitz and his staff, was very well received. On Thursday, Doctor M. H. Dawson gave an excellent paper on Chronic Arthritis. The fact that Doctor Lahey was unable to come was somewhat of a disappointment, but was largely atoned for by the fact that Doctor Marshal who took Doctor Lahey's place gave such an excellent address. Very favorable comment was heard concerning the papers of Doctor Hyman on Intravenous Drip Chemotherapy, Doctor Gold on Digitalis, and Doctor Barach on the Use of Gases in Therapy. The above are only a few of a long list of papers, each of which was extremely worthwhile.

Among the innovations was a small but interesting scientific exhibit. Doctor M. J. Schlesinger had an exhibit of hearts illustrating points brought out by Doctor Blumgart in his lecture on Coronary Artery Disease. Doctor H. E. Bacon had an exhibit of anorectal diseases, and Doctor E. Crosby had a very novel and interesting exhibit of emergency splints.

The luncheons, at each of which one of the guest speakers addressed the Congress in a question and answer session, were very well attended. The smallest number present at luncheon was one hundred and twenty two, and one hundred and seventy two attended on the day Doctor Joslin spoke.

The sixteenth Clinical Congress is history. The members of the committee, already thinking of next years Congress, have listened attentively to the comment of the members. As always, there have been some complaints, but this years program and the method of presenting it has been so well received and so well spoken of by many who attended, that the committee is encouraged to go ahead along much the same lines for next year.

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Paevex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

MEDICAL PERSONNEL FOR THE OPERATION OF THE SELECTIVE SERVICE

The Society's Committee on Medical Preparedness, in cooperation with Major William B. Smith, medical advisor to the Governor in the Selective Service, has recommended for appointment the medical personnel for the administration of the Selective Service Law. The State Committee on Medical Preparedness consists of: Chairman, George M. Smith; Fairfield County, H. Bertram Lambert, Bridgeport; Hartford County, Donald B. Wells, Hartford; Litchfield County, Francis Sutherland, Torrington; Middlesex County, George A. Elliott, Middletown; New Haven County, Ralph E. McDonnell, New Haven; New London County, Daniel Sullivan, New London; Tolland County, Donald M. Beckwith, Rockville; Windham County, Edward J. Ottenheimer, Willimantic; the President of the Society and the Secretary of the Society ex-officio.

MEDICAL ADVISORY BOARDS

Medical Advisory Board at the Veteran's Home, Rocky Hill, for the district consisting of Hartford and Middlesex Counties:

Chairman, Internist, G. Gardiner Russell, Hartford
Internist, F. Erwin Tracy, Middletown
Surgeon, Benedict B. Landry, Hartford
Orthopedist, Maurice M. Pike, Hartford
Otolaryngologist, William T. Morrissey, New Britain
Ophthalmologist, Carl C. Chase, Middletown
Dermatologist, Harry Bailey, Hartford
Pathologist, Louis P. Hastings, Hartford
Radiologist, Ralph T. Ogden, Hartford
Psychiatrist, C. C. Burlingame, Hartford

Medical Advisory Board at Uncas-On-Thames, Norwich, for the district consisting of Tolland, Windham and New London Counties.

Chairman, Internist, Alfred Labensky, New London
Internist, Albert C. Freeman, Norwich
Surgeon, Robert R. Agnew, Norwich
Orthopedist, Harold W. Wellington, New London
Otolaryngologist, Frank E. Wilson, New London
Ophthlmologist, Morton Arnold, Willimantic
Dermatologist, Charles M. Williams, Stonington
Pathologist, Maurice R. Moore, Norwich
Radiologist, Kenneth K. Kinney, Willimantic
Psychiatrist, William A. Bryan, Norwich

Medical Advisory Board at Laurel Heights, Shelton, for the district consisting of Fairfield County.

Chairman, Internist, Harold L. Amoss, Greenwich
Internist, Charles W. Gardner, Bridgeport
Surgeon, Daniel C. Patterson, Bridgeport
Orthopedist, Carl J. Gade, Bridgeport
Otolaryngologist, William F. Gordon, Danbury
Ophthalmologist, Edward N. DeWitt, Bridgeport
Dermatologist, James D. Gold, Bridgeport
Pathologist,
Radiologist, Berkley M. Parmelee, Bridgeport
Psychiatrist, William B. Terhune, New Canaan

Medical Advisory Board at the New Haven Hospital, New Haven, for the district consisting of New Haven County, exclusive of the City of Waterbury and the towns of Middlebury and Wolcott.

Chairman, Internist, George Blumer, New Haven
Internist, Thomas P. Murdock, Meriden
Surgeon, William F. Verdi, New Haven
Orthopedist, Denis S. O'Connor, New Haven
Otolaryngologist, Frederick N. Sperry, New Haven
Ophthalmologist, Arthur M. Yudkin, New Haven
Dermatologist, Maurice J. Strauss, New Haven
Pathologist, Milton C. Winternitz, New Haven
Radiologist, Hugh M. Wilson, New Haven
Psychiatrist, Lloyd J. Thompson, New Haven

Medical Advisory Board at the Waterbury Hospital for the district consisting of Litchfield County, the City of Waterbury, and the towns of Middlebury and Wolcott.

Chairman, Internist, John H. Foster, Waterbury
Internist, Patrick J. Brennan, Waterbury
Surgeon, Edward H. Kirschbaum, Waterbury
Orthopedist, Edwin Pyle, Waterbury
Otolaryngologist, M. Heminway Merriman, Waterbury
Ophthalmologist, William M. Good, Waterbury
Dermatologist, Richard J. Lawton, Waterbury
Pathologist, Joseph O. Collins, Waterbury
Radiologist, Joseph L. Harvey, Waterbury
Psychiatrist, Arthur H. Jackson, Washington

MEDICAL EXAMINERS TO SELECTIVE SERVICE BOARDS

HARTFORD COUNTY

Board 1A,	*Hartford.* Walter Weissenborn, Christopher J. McCormack, Peter J. Steincrohn.
Board 1B,	*Hartford.* Edward J. Turbert, Rocco J. Romaniello, William A. Wilson.
Board 2A,	*Hartford.* Samuel Donner, Burdette J. Buck, George A. Wulp.
Board 2B	*Hartford.* Timothy F. Brewer, Wilmot C. Townsend, John F. McGrath.
Board 3.	*Hartford.* Maxwell O. Phelps, Maurice F. O'Connell, Frank T. Oberg.
Board 4A,	*Rocky Hill, Wethersfield, Newington.*William F. Storms, Robert A. Goodell, Oran A. Moser.
Board 4B.	*East Hartford, South Windsor, Glastonbury, Marlborough.* Howard B. Haylett, Lee J. Whittles, F. Wellington Brecker.
Board 4C,	*Manchester.* Howard Boyd. George A. F. Lundberg, Mortimer E. Moriarty.
Board 5A,	*West Hartford.* Edward A. Deming, Philip F. Parshley, John F. McDermott.
Board 5B,	*Avon, Berlin, Burlington, Farmington, Plainville, Southington.* Walls W. Bunnell, Eric M. Simmons, Lawrence H. Frost.
Board 5C	*Bristol.* Ralph A. Richardson, William H. Flynn, Benjamin B. Robbins.
Board 6A,	*New Britain.* George H. Dalton, Raoul J. Benoit, Roman Lekston.
Board 6B,	*New Britain.* John C. White, Joseph L. Kalett, Joseph T. Matteis.
Board 7A,	*East Windsor, Enfield, Suffield, Windsor Locks.* Ettore F. Carniglia, William H. Upson, William G. Shepherd.
Board 7B,	*Bloomfield, Canton, East Granby, Hartland, Simsbury, Windsor.* Aaron P. Pratt. James E. Stretch, William H. MacCready.

NEW HAVEN COUNTY

Board 8A,	*New Haven.* Theodore S. Evans, James R. Coffey, Luca Celentano.
Board 8B,	*New Haven.* Arthur B. Dayton, Joseph D. Russo, Charles Sanford.
Board 9A,	*New Haven.* James A. Gettings, Robert G. Tracey, C. Seaver Smith.
Board 9B,	*New Haven.* William J. Dennehy, Edgar M. Johnson, Paul Vestal.
Board 10,	*New Haven.* Frank Mongillo, Barnett Greenhouse, Ralph W. Nichols.
Board 11A	*New Haven,* Frederick W. Roberts, Edmund F. FitzSimons, Thomas Russell.
Board 11B,	*New Haven,* Samuel J. Goldberg, Sr., Francis Reilly, Michael Shea.
Board 12A,	*Hamden, North Haven.* Sterling Taylor, Walter V. Corey, Frederick R. Ematrudo.
Board 12B,	*Branford, East Haven.* Charles W. Gaylord, Nathan Levy, Robert Taylor.
Board 12C,	*Guilford, Madison, North Branford, Wallingford.* James D. McGaughey, F. DeWitt Smith, Milo Rindge.
Board 13A,	*Meriden,* H. DeForest Lockwood, Michael J. Conroy, Israel S. Otis.
Board 13B,	*Meriden.* David P. Smith, Edward W. Foster, William E. Hall.
Board 14A,	*Cheshire, Naugatuck, Wolcott, Prospect.* Wilbur J. Moore, William E. Hill, Edward A. Herr.
Board 14B,	*Milford, Orange, Woodbridge, Bethany.* William J. Fischer, Harry Stetson, Allan K. Poole.
Board 14C,	*West Haven.* Platt Rogers, Victor A. Kowalewski, Harold S. Appell.
Board 15A,	*Waterbury.* Albert E. Herrman, Jacob Gancher, R. Harrison Ryder.
Board 15B,	*Waterbury.* Walter L. Barber, Alfred C. Dreher, Thomas Cottiero.
Board 16A,	*Waterbury,* Andrew J. Jackson, Richard J. Hinchey, Abe S. Brown.
Board 16B,	*Waterbury.* Arthur A. Johnson, H. Everett Allen, Max H. Ruby.
Board 17A,	*Beacon Falls, Middlebury, Oxford, Seymour, Southbury.* Orpheus J. Bizzozero, Oscar Rogol, John J. Casagrande.
Board 17B,	*Ansonia, Derby.* Samuel B. Rentsch, Anthony F. Alu, Thomas F. Plunkett.

NEW LONDON COUNTY

Board 18A,	*New London.* Richard M. Starr, Anthony J. Loiacono, Edward Gipstein.
Board 18B	*Groton.* Charles G. Barnum, Edmund L. Douglass, A. Joseph Leon.
Board 19,	*Ledyard. Preston, Norwich.* Clarence G. Thompson, William T. Driscoll, John W. Suplicki.
Board 20A,	*Bozrah, Colchester, East Lyme, Lyme, Lebanon, Montville, Old Lyme, Salem, Waterford.* Julian Ely, Cyrus E. Pendleton, Ellis K. Devitt.
Board 20B,	*Franklin, Griswold, Lisbon, North Stonington, Sprague, Stonington, Voluntown.* Thurman P. Maine, Earl G. Haliday, Martin L. O'Neil.

FAIRFIELD COUNTY

Board 21A,	*Bridgeport,* Francis J. O'Brien, Geroge A. Buckhout, Joseph M. Plukas.
Board 21B,	*Bridgeport.* Stanton R. Smith, Cornelius S. Conklin, Joseph C. Quatrano.
Board 22A,	*Bridgeport.* John S. Nickum, Isaac L. Harshbarger, David S. Greenspun.
Board 22B,	*Bridgeport,* Irving L. Nettleton, Fraray Hale, Max Alpert.
Board 23A,	*Bridgeport,* James P. McManus, Maurice N. Levy, Arthur J. Sekerak.
Board 23B,	*Bridgeport.* John A. Maxwell, G. Herbert Hooper, Charles W. Nichols.
Board 24A,	*Danbury.* William A. Sunderland, John D. Booth, Frank M. Goldys.
Board 24B,	*Bethel, Brookfield, New Fairfield, Redding, Ridgefield, Sherman.* Francis B. Woodford, Francis Brewer, Russell W. Lowe.
Board 25A,	*Easton, Fairfield, Weston, Westport.* Sidney L. Biehn, Harry S. Phillips, Joseph J. Smith.
Board 25B,	*Monroe, Newtown, Shelton, Trumbull.* Frank Wales, Waldo F. Desmond, Edward J. Finn.

Board 25C, *Stratford.* Frank C. Buckmiller, Harold T. Oesau, Allan D. Ashcroft.

Board 26A, *Darien, Norwalk.* William J. Tracey, Henry C. Sherer, William H. McMahon.

Board 26B, *Norwalk.* George G. Fawcett, Henry K. W. Kellogg, Eugene C. Beck.

Board 27A, *Stamford.* Ralph W. Crane, Charles L. Dichter, A. Frederick McGourty.

Board 27B, *Stamford.* J. Howard Staub, William E. Smith, Francis C. McMahon.

Board 27C, *Greenwich.* Joseph V. Shermak, J. Leonard Vickers, Aaron B. Gates.

WINDHAM COUNTY

Board 28, *Ashford, Eastford, Killingly, Putnam, Thompson, Woodstock.* Karl T. Phillips, William Mac Shepard, Cecil R. Garcin.

Board 29, *Brooklyn, Canterbury, Chaplin, Hampton, Plainfield, Pomfret, Scotland, Sterling, Windham.* Fred M. Smith Michael D. Riordan, Arthur D. Marsh.

LITCHFIELD COUNTY

Board 30, *Goshen, Harwinton, Litchfield, New Hartford, Torrington,* Harry B. Hanchett, Floyd A. Weed, John F. Kilgus.

Board 31, *Barkhamsted, Canaan, Colebrook, Cornwall, Kent, Norfolk, North Canaan, Salisbury, Sharon, Winchester.* Robert C. Sellew, Chester F. English, Howard R. Hansell.

Board 32, *Bethlehem, Bridgewater, Morris, New Milford, Plymouth, Roxbury, Thomaston, Warren, Washington, Watertown, Woodbury.* Frederic W. Wersebe, Edwin G. Reade, Winfield E. Wight.

MIDDLESEX COUNTY

Board 33, *Cromwell, Middlefield, Middletown.* George M. Craig, Walter N. Nelson, Benjamin A. Roccapriore.

Board 34, *Chester, Clinton, Durham, East Haddam, East Hampton, Essex, Haddam, Killingworth, Old Saybrook, Portland, Saybrook, Westbrook.* William J. Tate, Philip E. Schwartz, Frederick B. Bradene.

TOLLAND COUNTY

Board 35, *Andover, Bolton, Columbia, Coventry, Ellington, Hebron, Mansfield, Somers, Stafford, Tolland, Union, Vernon. Willington,* Elliott H. Metcalf, Roy C. Ferguson, John P. Hanley.

MEETINGS FOR MEDICAL EXAMINERS AND MEMBERS OF MEDICAL EXAMINING BOARDS

Volume VI of the Selective Service Regulations has not yet been received from the Selective Service Board in Washington. This volume will contain the Regulations for Physical Examinations and Physical Standards under the Selective Service Act. As soon as these are available meetings will be held in each of the five Advisory Board Districts to which all Medical Examiners and members of Advisory Boards will be invited. Representatives from the Connecticut Selective Service Board will be present to explain the regulations and answer any questions concerning the conduct of examinations. Notices of the meetings will be sent to all physicians who are to serve with the various Boards.

——☆☆——

The X-ray examination of recruits in Australia is to be extended to the permanent military forces. Every member of the forces will be re-radiographed on his return from abroad. The incidence of active pulmonary tuberculosis was 0.55% among the 9,000 men examined. Eric Coope, M.D., *British Med. Jour.*, Aug. 24, 1940.

——☆☆——

AMENDMENT TO SELECTIVE TRAINING AND SERVICE ACT

(*Continued from Page 671*)

sicians, surgeons, and dentists at recognized hospitals, shall be exempt from training and service (but not from registration) under this Act. Notwithstanding any other provision of law, any such medical or dental student, interne, or resident physician, surgeon, or dentist who is a member of a reserve component of the land or naval forces of the United States shall not be ordered or called to active duty or into active service in any of such forces without his consent, except in time of war."

(A companion bill H.R. 10587, introduced by request, by Representative McCormack, is pending in the House Committee on Military Affairs.)

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

(SEE PAGE 2)

Connecticut Hospital Association

THE HOSPITAL SECTION OF THE STATE MEDICAL JOURNAL

On November 22 the annual meeting of the State Hospital Association will be held and one of the questions which must be discussed and decided at that time is: Shall the Hospital Association continue its section in the State Medical Journal? Last year when this question was being considered, it was the concensus of opinion that it would be a very worth while plan for our association to carry on. It would provide an excellent medium for an exchange of ideas regarding hospital administrative problems and would aid in a closer relationship between the hospitals and the members of the medical profession. It would also contain personal items and news notes of institutional activities. To pay for it we could get advertisements for the Journal. No one was so optimistic as to think we could get a sufficient number of ads to show a surplus, (hospital administrators never think in terms of surplus), but we should cover the cost. Nearly a year has passed and if we are to answer the question by the results of this year, the answer, in our opinion, must be "No." The Editor has had to dig the news items out with a pickax. A few reports of real interest have been submitted but aside from these the various issues have looked like an anaemic, premature baby — which has shamed the Editor to the point of resigning the job as soon as this year is over. Probably someone among our members with more drive or more persuasive power can get articles, news items, interesting statistics, etc , from among our membership.

As for the cost, only one advertisement was secured aside from those appearing in the convention issue and as a consequence we shall operate our share of the Journal this year at a loss.

Next year, if we were to continue, somebody must get busy and secure $1,500.00 worth of advertising.

This is not a very cheerful picture but it pretty well describes the situation. What is the matter with our hospital people? Aren't we interested in our institutions? Aren't we proud of the things we are doing? Don't we want to tell the other fellows about them? Have we no bond of good fellowship, of understanding, of mutual helpfulness among us? Have we no ideas we care to express, ideas that would attract attention and discussions? Are we so bound up in ourselves that we don't care about our co-workers? If that's the situation, let us not only drop the Journal but the Association too.

But the Editor doesn't believe these things represent our attitude. At a ripe old age, he still has a big gob of optimism. He feels that this group of administrators, members of the State Hospital Association, many recognized as leaders in this profession, can do a splendid job in promoting the hospital section of the Journal.

Let's have a carefully considered decision at the November meeting.

* * * *

THE COMMISSION ON THE PREVENTION AND CARE OF SICKNESS

On Friday, September 27, this Commission held a conference with Hospital Superintendents, social workers, school nurses and others from every part of Connecticut, all of whom have a close daily contact with this problem.

The questions asked by Dr. Barker, Chairman of the Commission, developed a great deal of worth while discussion. Mr. Bartine, of Bridgeport, spoke at some length relative to the shortage of hospital beds to meet the ever increasing demand for hospitalization. This led at once into the matter of caring for convalescents and, more particularly, providing facilities for the chronic ill. From the interest displayed it was evident that this phase of the problem was considered most important.

The care of children suffering with rheumatic heart and other conditions which required long hospitalization was another phase fully discussed.

Another need which was stressed was the provision for more out-patient service to the ambulatory person and the opportunity of including in this service persons with a higher income than now are cared for.

It was a most profitable afternoon for those in attendance if not for the Commission.

* * * *

A REPORT FROM THE HARTFORD HOSPITAL

The Hartford Hospital completed its busiest year on September 30, 1940. Total in-patient admissions were 19,570, a gain of 10.5% over the previous year. There were 2,399 deliveries, an increase of 13.6%.

During the year, the necessary property for the new building program was acquired and a number of steps taken, forwarding this project.

A new floor, accommodating twenty-two semi-private patients, was constructed on top of the East Building and has had a high occupancy since its opening. Also of interest is the purchase and installation of an electroencephalograph, perhaps the newest and most complicated apparatus in the medical armamentarium.

It is interesting, in line with the growth of hospitalization insurance, that, excluding newborns, 25.5% of all admissions were covered by the Connecticut Plan for Hospital Care, or by hospitalization, compensation or liability policies. There seems to be no doubt that these types of coverage meet a real demand and have come to stay.

* * * *

A CORRECTION

In that excellent report from Bridgeport Hospital submitted by Mr. Bartine, which appeared in the October issue of the Journal, it states, "daily average number of visitors—10". Mr. Bartine informs us that these statistics should read, "daily average number of visitors' meals — 10." He goes on to say that they have an average number of about 1,200 visitors to the patients of the hospital each day.

Enlarging upon this important phase of the hospital's contact with the public, Mr. Bartine says: "This is a very important problem in connection with a hospital and the young women in charge of our information desk are given specific instructions as to the proper procedure of receiving visitors. We feel very strongly that an unfriendly reception at the information desk creates a bad impression of the entire hospital."[1]

---

[1] Editor's Note. Mr. Bartine touches on one of the most important phases of hospital public relations and his words are worthy of serious thought by all hospital administrators.

* * * *

TRUSTEES MEETING

At the meeting of the Trustees on October 11, arrangements were made for the annual meeting which is to be held at the Lawrence Memorial Hospital in New London on Friday, November 22. It is planned to have the meeting start promptly at 11 A.M. and the business of the Association will be taken up at the morning session, an address and an open forum for the afternoon sessions.

Important. Every member is urged to bring as many members of his Board of Directors as possible to this meeting and also such other employees in his hospital as may be interested.

It was reported that thirty-seven copies of the Connecticut Hospital Statutes have thus far been sold. The trustees were agreed that careful study of these statutes would indicate their value for the legal council of the hospitals and for the president of hospital boards and other members of the boards who may be interested. It was decided that hospitals should be urged to purchase the remaining copies of this publication and present them to these officers.

At the meeting of the trustees, Mr. Sweeney told of a very interesting development in the eastern section of the state. On the evening of October 2, a meeting of trustees representing the hospitals in the eastern section of the state was held at Norwich Hospital. An address by Mr. Raymond Sloan, Associate Editor of *Modern Hospital* was followed by a long discussion with many questions asked and answered. As we remember it, this was a very rainy night but Mr. Sweeney reports there were about fifty trustees present and they decided to create a permanent organization to meet bi-monthly.

This is a very interesting development and one which ought to be carried on by hospitals in various sections throughout the state. We need this interest of the directors very much indeed.

If you are interested in the legal phases of hospital operation, we recommend that you purchase the latest edition of a book by White & Hoyt entitled *Legal Aspects of the Hospital.* In addition to a complete coverage of these legal aspects, the volume of nearly five hundred pages includes all of the later decisions in court cases affecting hospitals and is so carefully indexed and cross indexed as to make information readily available.

* * * *

WINDHAM COMMUNITY MEMORIAL HOSPITAL

The annual budget campaign for this hospital was carried on during the week of October 14-21 for $12,500. As we go to press we are not in a position to tell about the results but it is our guess that it will go well over the top as it has in every year since it has been put on. The hospital is one of our very best institutions in the state and is doing a splendid work. Every reader should get a copy of the material which Bill Sweeney has used in that campaign. It is of intense interest to hospitals generally and of great interest to the people of Windham County. It is the kind of stuff that will get real and intelligent hospital support.

* * * *

WHO IS YOUR LOCAL CANDIDATE FOR THE STATE LEGISLATURE?

This may prove to be a very pertinent question about next January when we call on you to cooperate in writing your Senator or State Representative regarding some bill which effects your hospital operation.

There need be no element of political partisanship in your attitude when you contact your candidates. Most of them are good American citizens and want to do the right thing by their neighbors. If you make certain that they know something about the problems of running a modern hospital, you will have less trouble getting a hearing when the Legislature is in session.

One of the problems which we may face in the next Legislature arises from the desire of some departments in the State government to avoid the use of private hospitals. Certain institutions must be operated by the public but there is no justification for constructing new general hospitals in outlying sections of this State. In the final analysis, the sick poor will be the sufferers and it is our duty to see that every elective official knows the facts regarding hospital facilities in his locality.

You can talk and demonstrate very easily now. When the Legislature is in session, the pressure on its members is so heavy that the folks at home are seriously handicapped in making known the truth. Letters and wires pile up on their desks from many sources on all manner of subjects and the confusion is devastating. Now is the time to work.

The Council on Government Relations asks that you give serious thought to the implications of the proposal that the State take over all hospital charity work. This would involve the construction of new general hospital facilities. As general principle, any public funds available for hospitalization should go for the care of the sick and not for additional hospital buildings.

* * * *

OPENING OF NEW INSTITUTION FOR MENTAL DEFECTIVES AT SOUTHBURY

Ernest H. Roselle, Superintendent

When Connecticut's new institution for mental defectives is dedicated on November 9, and announces that it is ready to receive, care for and, where possible, train the state's lengthy waiting list of mental defectives, it will mark, not only a new milestone in the State's social and humanitarian work, but it will also bring to consummation a dream long held by many of its citizens.

For a decade and a half there has been need for and pressure for a new institution for mental defectives. The waiting list for the Mansfield State Training School and Hospital has continued to grow and grow, inasmuch as that institution has, for years, been able to absorb only a limited number of those needing institutional care. Groups throughout the State, conscious of the need, have actively sponsored the need of a new institution and many have participated in one way or another in practically every chapter involved in its creation.

Therefore, when the new institution, located "among the picturesque hills of Southbury" as the press has so aptly and accurately stated, opens its doors to facilities that are as complete and as modern as those provided to serve this problem by any commonwealth within the nation, many groups and individual citizens can feel that they have written themselves in one way or another into the brick and mortar of those buildings and into the program which shall for generations to come serve the State and its people in those problems which surround society's care of those who have come to us with, or who have acquired through no fault of their own, imperfect minds.

The Approach

The Commission appointed by Governor Cross following legislation by the 1935 Legislature comprised the following:—Mr. Charles A. Moser of Stamford; Mrs. Sidney G. Davidson and Dr. Grover Powers of New Haven; Mr. Morgan Brainard of Hartford; Mrs. Sara B. Crawford of Westport; Mr. F. Kingsbury Bull of Litchfield and Mr. Clarence King of New Canaan. The subsequent resignations of Mr. Brainard and Mrs. Crawford have been filled by the appointments of Mr. William L. Mooney of Hartford and Mrs. Ella G. Fleck of Stratford, respectively. No one would have expected this splendid group of representative Connecticut citizens to approach their problem in anything but a thoroughgoing manner, or to create anything commonplace.

After organizing their Commission and its approach to the problem, the Commission set out in groups and as a whole to study institutions in this and other states. Some nine institutions were thus studied on the ground. Time was taken to get a good general view of each institution, its program, staff and plant. Some visits included overnight inspections and studies. Conferences with the staffs were held. Much data was collected for study and analysis. Practically a year was spent in this study.

Decision on Characteristics of Institution

Out of these observations and studies the Commission decided that the institution which they would recommend to the Governor and the General Assembly for Connecticut must possess the following general characteristics:

(a) That while recognizing other services and their important place in the work, the problem of mental deficiency in an institution was predominantly one of conditioning and training the inmates for more happy and more effective living within the institution and for possible parole, depending upon mental level and outlook — and that this required an institution so planned and so staffed that it could meet these major and related objections.

(b) That the institutional plant to be built must not only be planned around the specific functions which each unit is to perform; but that the traditional large congregate institutional units must give way to an institutional plant that would parallel, as closely as possible, a normal community, for it is to house largely children, and "children have the inalienable right to be reared in conditions approaching as closely as possible those of a normal home and community."

The Site

While these studies on the plant and program were underway and the prescription was being written for them, the Commission, having already developed specifications for a site, inspected some eleven different sites suggested for the location of the institution. These were located more or less centrally in the western half of the state. The site finally chosen is in the Town of Southbury. It comprises some 1400 acres, including an attractive valley site for the institution with proper exposure, providing in every manner a village aspect; and abundant underground water supply of excellent quality and approximately 1200 acres of contiguous hilltop farm and grazing land for the large farm enterprise planned from the first as a highly essential part of the institution. The site has lent itself very effectively to the placement of the type and scope of institution projected.

Developing the Plans for Program and Plant

Having determined in a general manner the kind of institution and program they desired to create, and having purchased a site upon which to build the physical plant, the Commission at once turned its attention to bringing into reality its hopes and plans for the new institution.

Realizing that they would need the services of technically trained persons to develp their plans for a project of the size and character contemplated, they employed with the approval of the state late in 1936, two such persons — one with a broad background in institutional planning, and the other trained and experienced in institutional administration with a thorough background in education and training, who would, when the institution was completed, become its administrator.

With this staff, later augumented by a practical plant engineer, the Commission immediately began intensive work in developing first the outlines of the program of care and training to be operated and then the plans of the physical plant to house it.

Critical Review by Experts

At the close of two months' work on these, the Commission decided on having a critical review made of its entire approach and preliminary plans. With the active assistance of Governor Cross a group of twenty outstanding experts in the field of mental deficiency, comprising heads of national organizations in the field, state commissioners of welfare, research directors, and superintendents of many of the leading institutions of the East was invited to attend a two day conference in New York to review with the Commission and its staff in a critical manner the Commission's plans for program and plant. Illness prevented the attendance of two. All others participated. Two days of intensive conferences were held with minutes preserved of all discussions. The conference is, of course, epochal in the development of the project. It did much to crystallize the Commission's thinking. Many of those who participated in the conference have remained in close touch with the planning of the institution and several have rendered an outstanding service by periodic checking.

Prospectus and Plans

The month following the above conference a Prospectus, presenting in some forty pages the outlines of the program and preliminary plans of the institution, was prepared and presented to Governor Cross and the General Assembly.

Plans to the Department of Public Works

Some months later, on July 1, 1937, when the Department of Public Works assumed office, the Commission was relieved of the responsibility placed on it by the General Assembly of 1935 "to build another training school and hospital for the feebleminded" by the creation of this new Department. The Commission at once turned over to this department its preliminary plans for the institution and since that date, though without specific authority, has cooperated with the Department of Public Works to the end of securing the physical plant projected. The plant as it nears completion is, with the exception of a central power plant (unit heating was sought), essentially the plant as planned by the Commission. The Department of Public Works has given its active cooperation to this end.

Hospital Building, Southbury Training School.

The Institution Prepares to Open

The institution will have a total bed capacity of 1500. Present plans provide for receiving 150 each three months. This number is dictated somewhat by counsel from experts in this field to the effect that it would not be to the best interests of the institution and to the State to attempt to receive defective persons, particularly those who have not heretofore been institutionalized, at a faster rate than this. Institutions which have attempted to receive larger numbers have not been particularly successful in so doing. The number is also definitely dictated by the amount of funds which can be made available by the Governor and State fiscal officers for the operation of the new institution in the current biennium.

Some of those admitted will comprise persons now in Mansfield institution who have been committed from the western half of the State. The remainder will come from those on the waiting list who now reside in the western portion of the State — which is now to be served by the new institution. Miss Mabel Matthews, Social Service Director of the Mansfield State Training School and Hospital, is in charge of admissions to the new institution under the direction of a joint committee of both boards, already functioning. The work is centralized in a well equipped and staffed office in the State Office Building in Hartford.

This arrangement may prevail permanently and will at least do so until the new institution is well on its way.

The Program

Now as to the program to be operated. Mental deficiency on the basis of the degree of the defect and thinking of it as a practical problem for society to face, divides itself into two problems. The first is that of the idiot and lower grade imbecile child where the defect is so serious as to make the child essentially a helpless person; requiring the care and attention given to an infirm, irresponsible individual. The care of these children, tragic in their helplessness, affects directly, however, but a very narrow sector of society, represented largely by the members of the immediate family, their physician, perhaps the visiting nurse and social worker. If there are other children in the family, particularly if they are normal, it is indeed a tragic situation within that family circle, but its influence beyond this circle is decidedly limited. The percentage of this group to the whole group of mental defectives is relatively small.

The very much larger group represented by the higher grade imbecile and the moron, generally of fair to even rugged health, gives concern to the family in their care and direction, it is true, but usually of quite a different type. They meet far less frequently the doctor, but they do sooner or later come into contact with a much larger sector of society as represented by the teacher, the social worker, law enforcement officials, etc. Unlike the former group they are of concern to society from the standpoint of eugenics, because most of them are reproductive.

The very range and diversity in the nature of these two problems, each within the scope of the larger problem of mental deficiency, accounts probably for much of the confusion which exists in society's efforts to meet the problem. To some, the mental defective is a helpless infirm child; to others, a healthy, able bodied, but more or less irresponsible and incapable individual. Cognizant of this wide diversity in the needs represented in this problem the Commission has projected in the new training school practically two institutions and two programs in the same institution.

Homelike Cottage for 30 Children, Southbury Training School

For the Lower Grade Child

For the lower grade child various degrees of infirmary care are contemplated. Facilities of an infirmary type are being provided in comparatively large units housing from 60 to 90 each. The employees in these units will be of the nurse attendant class. The facilities are such that a considerable range of classification can be provided in each unit, permitting the placing of bed cases on isolated second floor wards with sun decks and solaria adjoining; and for the various degrees of ambulatory cases other facilities adapted particularly to their care. The attendants who care for these children will live when not on duty in a very pleasant and complete housing unit located in that particular area of the institution. This entire area is located on the higher levels of the institution, removed from the morbidly curious and where the quiet and seclusion so desirable for this type of child can be easily secured.

It is likewise in close proximity to the institution's very completely staffed and equipped hospital and this section of the institution will, of course, receive much of its direction and supervision direct from the medical staff of the institution, who will be constantly in touch with its attendants and their charges.

Also in close relationship to this section of the institution, and particularly to those units housing the middle grade children, are two occupational therapy and industrial training units — one for each sex. These units will offer a considerable range of occupational therapy and low grade training activities — the former largely for their therapy values and the latter not only for these values, but also to offer facilities enabling this class of inmate to assist in the maintenance of the institution by the production of essential articles.

Program for High Grade Children

For the higher grade child with I.Q. ranging in general from 40 or thereabouts up, quite a different range of facilities is being provided. These children will be housed in New England colonial homelike and non-institutional appearing residential units accommodating from 22 to 50 each and averaging approximately 32 each. These cottages are placed in village formation on the rolling terrain which forms the lower and front sections of the institution Each cottage is a complete household unit with its own kitchen, dining room, three section living room to provide for different interests, dormitories and quarters for the cottage staff, all furnished with homelike equipment. Each cottage is surrounded with plenty of lawn and play areas. The boys' cottages will be in charge of a married couple and the girls' cottages in charge of a mature woman as matron with assistant matrons. Where health and capacity will permit the children will participate in the daily routine of household duties required for their maintenance. These facilities will provide an abundance of training daily for those children who can profit by it, and in the very vocations to which it is easiest to parole mentally subnormal persons. The number of these cottages—some 23—will offer excellent opportunity for classification of this type of inmate on the basis of different criteria such as — age, mental level, progress through institution from reception to parole preparation, state of health such as epilepsy, behavior types, etc.

One cottage of this group accommodating forty young men is located on the farm. It will be organized as the other cottages, and the inmates will form a large part of the farm labor group. This will make it possible for this group not only to assist materially in the maintenance of the entire institution by the production of dairy, garden and general farm food products, but also provide the means to train these possible parolees for one of their best outlooks, viz., that of farm laborers and helpers.

The School Unit

In the center front of the institution, between the boys' and girls' training villages, is located the school or training unit. This unit is most complete. The group to be trained in institutions for mental defectives constitutes perhaps the most difficult of all our social groups to train; and yet most of these institutions are provided with pitifully inadequate training facilities and personnel to meet their responsibility. The Southbury institution will undoubtedly set a new level in the variety and character of these facilities. Certain classrooms will be provided for that relatively small proportion of these children who can profit in any manner from so-called academic education and even this instruction will have much motivation through motor activity. Most of the training facilities in the school will, of course, be in the nature of shops where the children will be given such vocational training in household arts, wood, metal, textiles, etc., as they are able to profit by. A number of the shops will be service shops where essential services for the institution will be performed and products manufactured. The barber shops, for instance, will be located in this unit both to serve the institution and to provide opportunities for low grade training in these vocations. A clothing factory where much of the clothing required for the institution will be manufactured will be located here for similar purposes. A shoemaking shop will repair and manufacture shoes. A complete store for girls' furnishings and one for boys' will likewise be located in the school for much the same purpose, replacing the warehouse or commissary plan used by most institutions in dispensing these supplies; which has little or no resemblance to normal community store facilities and therefore offers no opportunity for training institutional children for meeting these life situations when parole places them without the shelter of the institution. The school, likewise, contains the community auditorium, seating 1,000 and two small physical training rooms or gymnasia to make use of these very fruitful means of training the handicapped child. An educational research unit completes the school plant, and will place at the elbow of the school supervisor the use of the cold light of science in measuring the effectiveness of his program and for improving the methods used.

This very complete unit and its staff will be made available to the teachers' colleges of the

State for use as a laboratory in the training of special class teachers.

Hospital and Health

The medical staff of the institution, already referred to in the section dealing with the infirm child, will, of course, have charge of all Medical and Health Services, will represent the medical aspects of all training and care problems in the institution and will have the fullest professional freedom in the discharge of these important duties. It will have a staff of assistant physicians reaching three when the institution is filled to capacity, together with a dentist and requisite nurses and technicians. To this position there has already been appointed Doctor Herman Yannet, who comes from the Department of Pediatrics at the Medical School of Yale University, where his interests for ten years have included not only the general medical care of children, but also broad interests in neurological psychiatric and associated disorders.

The hospital of fifty bed capacity is unusually complete in its facilities, not only for current resident and outpatient care of the institution's population but also for the scientific study of the medical aspects of mental deficiency and their implications.

Plants and Business Services

The services immediately involved in the care and training of the population of an institution are, of course, paramount in its work; but contributing services such as plant operation and maintenance, business and farm management, etc., have a large bearing on the efficiency of the institution in meeting its major obligations. The time and energy of many boards of management and their executive is frequently ursurped to a large degree by problems connected purely with the physical plant and its operation, leaving far too little time for them to deal with their real work involved in the handling of those human problems for which the institution exists.

With the above situation in mind the institution has not only been functionally planned in its physical plant to provide high quality in these services, but it is being staffed with individuals in these departments who are abundantly capable of carrying their problem. The Commission has definitely planned that the new institution shall be operated on the same principles of business efficiency which characterize a successful business enterprise.

Housing for Employees

The housing for employees is on a high standard. Much of the problem is a drab one and in planning these facilities it was felt that the securing and holding of high class personnel essential for success in the work depended to no small extent on the character of the living accommodations provided for those who must live in and become a part of the institutional community. There was also the additional determining factor that charges for rent made by the state to each employee living on the property will maintain the property and in periods varying from fifteen to thirty years completely amortize the cost of the buildings and residences provided.

Conclusion

The project is established. On the masthead of its printed forms, under the name of the institution, there will be carried the following statement:

Dedicated in a service to the mentally handicapped child that "will early discover and diagnose his handicap, provide care and treatment, and so train him that — if possible — he may become an asset to society rather than a liability."

With this statement of high purpose, drawn in the quoted words, from that historic document, The Children's Charter, the living modern Magna Charta of Childhood, the institution will go forward on a high plane in the performance of its mission.

It will still need the support and guidance of those citizens and groups that have brought it into reality; but it hopes these groups will continue to give leadership in the communities throughout the state that will inspire these communities to meet, so far as possible, the problem of the defective in their own midst; through better homes; better community recreation; better health programs; schools better adapted to serve the needs of all the children of all the people; to the end that no child shall be committed except as last resort to any institution; for the best institution in the world is a poor substitute for a good home in the rearing of a child.

RED CROSS TO SUPPLY ENGLAND WITH BLOOD PLASMA

To the long list of drugs, surgical instruments and hospital supplies which the American Red Cross has furnished its British sister society to help relieve distress caused by the war, is now to be added a new substance: blood plasma solution. Plans for this emergency project, the first of its kind in history it is believed, were initiated by the American Red Cross and the Blood Transfusion Betterment Association of New York City, during the summer.

Under the plan as worked out, this latter organization assumed responsibility for the technical and scientific aspects of the program, while the Red Cross took charge of mobilizing thousands of volunteer donors in greater New York, and shipping the plasma to England.

Action on this project followed an appeal from the British Red Cross. The Blood Transfusion Betterment Association offered its facilities, assigning Dr. John Scudder of its staff to assume responsibility for organizing the collection of plasma from volunteers.

Dr. William DeKleine, national medical adviser of the American Red Cross, in announcing the project explained the newly-perfected plasma saline mixture would be used in this work. This method greatly facilitates storing and shipping. At the outset of the program the British Red Cross was prepared to handle 300 liters of the solution each week.

Announcement of the plan to aid the British Red Cross was made following completion of experimental plans for the possible organization of a nationwide corps of Red Cross volunteer blood donors whose plasma would be available to the several medical services of the United States government in case of national emergency. This project was started last summer in three cities of the United States in a preliminary study designed to perfect methods of collection, storage and transportation. Other cities were subsequently added.

Blood donations are not the sole volunteer activity on behalf of Europe's war victims that might be of interest to the medical profession. Ever since the war started last fall, great numbers of women have been at work in communities throughout the country making surgical dressings and bandages, hospital garments and other supplies for use in caring for the sick and wounded.

The number of surgical dressings produced by these volunteer Red Cross workers that had been sent abroad as of August 1 aggregated 3,787,000. Others were in the warehouse in Jersey City awaiting shipment. Additional dressings were being received daily, as the production schedule called for completion of 16,500,000 by September 1. Some little time would necessarily elapse, however, before all these were received at the Red Cross warehouse.

All war relief operations of the Red Cross are being conducted without interfering in any way with local chapter and national programs at home. These activities which are of primary importance, are supported almost in their entirety from the yearly dues collected from members during the annual Roll Call.

In the near future a large increase in Red Cross domestic activities is anticipated. To make this expansion possible, the membership rolls of every Red Cross chapter in the country over must be materially increased. Every member of the medical profession, in Connecticut as well as other states, is urged to join his local chapter during the annual Roll Call, November 11 to November 30.

-The-
General Practitioner's Forum

Enough evidence has accumulated to indicate that sulfathiazole may replace sulfapyridine in the treatment of pneumonia. In a series of 400 consecutive unselected cases treated at Bellevue Hospital, half received sulfathiazole and the others received sulfapyridine. The mortality for the newer drug was 11.7% as compared to 13% for the older one. However, certain more definite advantages were demonstrated. Nausea and vomiting occurred in only 10% as compared to better than 50% for sulfapyridine; renal complications were rare and the incidence of calculi much lower; it was absorbed more readily and excreted earlier with less toxicity. It was also demonstrated to be less readily conjugated in the blood-stream, and since it remained longer in a free state, activity was prolonged. Twelve of the 400 cases did not respond to chemotherapy and after 48 hours were treated with specific sera. Two of these cases died. The initial dose of sulfathiazole was 2 grams and was followed by 1 gram every 4 hours. Indications for stopping treatment are the same as for the older drugs. However, it was stressed that the total white blood cell count was not as indicative as the differential. The danger sign was a definite drop in the granulocyte count.

The Clinical Congress at New Haven was unusually attractive this year in the number and excellence of the papers presented. Many of them were of particular interest to the general practitioner and we hope that they will be published for the benefit of those who missed the presentation. Of the many useful statements we have permission to quote the following: (Barach on Gas Therapy) "Oxygen inhalations during the treatment of acute rheumatic fever will reduce the incidence of valvular heart disease." "Helium-oxygen mixtures plus rectal administration of 10 to 15 grains of aminophyllin will control the severest cases of asthma." (Crohn in the discussion of Peptic Ulcer) "In spite of the many new and complex alkalisers, still use, to our complete satisfaction, the old reliable sodium bicarbonate, heavy magnesium oxide and calcium carbonate combinations." (Dawson on Gold Therapy of Arthritis) "A valuable addition to our therapeutic armament, but it must be carefully watched for toxicity."

In an informal talk on Psychiatry, Burligame of the Hartford Retreat, reemphasized the close relationship between somatic and psychogenic medicine. Modern research is uncovering many dietary, infectious and endocrine factors in the evolution of psychoses and psychoneuroses. Conversely, it is being demonstrated that emotional stresses produce definite pathological entities. Pointedly addressing his remarks to the general practitioner he stated that no patient ever should be dismissed with a curt 'there is nothing the matter with you.' It may be a technically correct statement, but from the patient's point of view it is all wrong, for he would not be consulting you if it were otherwise. To the neurotic, it is doubly so; it convinces him that he made a mistake in coming to you and serves to push him into the hands of the charlatan. The family doctor holds a key position in the prevention and cure of the psychoneuroses, and he must prepare himself to meet the burden of an increased incidence. His knowledge of the family associations and backgrounds, its social, economic and educational deficiencies, its emotional maladjustments, is an essential step toward a cure. Recognition of these factors as active producers of psychogenic upsets will stimulate preventive therapy. Prophylaxis is essentially an emotional reconditioning. The mind must be trained to meet reality rather than to seek an escape from it. This can be accomplished by training for the young and re-education for the older ones. Logically, the starting place is in the home under the guidance of the family doctor.

T. P. R., M.D.

Our Neighbors

NEW YORK

The Westchester County Medical Society on October 9 held a meeting at the Westchester Division of the New York Hospital in White Plains for the purpose of organizing a General Practitioners' Section of that Society. Commenting on the contemplated section, Laurence D. Redway, Editor of the Westchester County Bulletin writes:

> "Practically every other section of the profession is organized and its interests well served. This is an assertion that nobody will care to challenge. The general practitioners will continue in status quo or go on to better things exactly in proportion to the interest they evince in their own affairs. The assumption of responsibility, like charity, should begin at home."

Only in Michigan, as far as we are aware, has any such section been organized within a medical society. The general practitioner may find it to his advantage to become thus organized in a day of specialization.

Another new scheme for low cost medical service has gone into effect. This time it is Local 802 of the American Federation of Musicians, one of the largest labor unions in New York City, which, with the participation of City officials and labor leaders in its inaugurating ceremony, started an hospitalization and medicine program for indigent members. The new plan calls for the division of the city into eight districts, in each of which the union has retained a physician who is also a member of the staff of the hospital. These physicians will pass upon the needs of unemployed members of the local and their families residing in the districts. There is no free choice of physician. The practitioners associated with the plan are employees of the union and wholly subject to lay direction. To quote the New York Medical Week:

> "If this scheme is extended to the working, self supporting members of the union — we may expect to see scores of schemes for cheap practice springing up in other unions, industrial plants, and benevolent organizations. The result will be as demoralizing to the prevailing standards of medical care as the low grade contract practice which paved the way for compulsory sickness insurance in England."

Doctor Willard Cole Rappleye, Dean of the College of Physicians and Surgeons, Columbia University, has been appointed Commissioner of the Department of Hospitals, New York City. In order to accept this appointment by Mayor LaGuardia, Doctor Rappleye has been granted a leave of absence from P. & S. for fifteen months. Doctor Rappleye had had a brilliant career, both as a teacher in medical fields and as an hospital administrative officer. It was from 1922 to 1926 that he served as professor of hospital administration at Yale and superintendent of the New Haven Hospital.

- NEWS -

from County Associations

Fairfield

The semi-annual meeting of the Fairfield County Medical Association was held at Laurel Heights Sanatorium, Shelton, on Wednesday, October 2. During the routine business session, Doctor Ralph W. Crane, of Stamford, presented a most interesting Vice-president's address entitled, "Experiences of a Medical Examiner." The scientific program of the evening, following dinner, was presented by Doctor E. J. Lynch, Superintendent of Laurel Heights Sanatorium, and his associates. After welcoming the members of the Association, Doctor Lynch told of the growth of the institution and the progress that had been made in the treatment of tuberculosis patients. He showed some very interesting slides on the modern methods of administering x-ray to the patients in this institution. Doctor Frederick Warring next presented "The Examination of the Patient and X-ray Therapy in theTreatment of Tuberculosis." Doctor Arnold Rilance followed with a most concise paper on "Collapsed Therapy," which was demonstrated with slides. The next speaker was Doctor Kirby Howlett, whose subject was "Collapsed Pneumothorax". Doctor Harold Goetz presented a most interesting paper on "The Treatment of Tuberculosis by Phrenic Nerve Paralysis," also demonstrated by lantern slides. The final speaker was Doctor Lee Reid, who explained the treatment of tuberculosis by thoracoplasty and the Jacobian method. Needless to say, the symposium was most instructive and the members present expressed their gratification of the program.

The County Association regrets deeply the loss of one its long standing members, Doctor Michael J. Rowe, who recently died.

Through the initiative of the Board of Trustees of the County Association, an appointed committee has organized a Medical Golf Association and is planning on four or five golf meets during the following year. This activity has received enthusiastic support.

After three months' summer recess, the monthly meetings of the Stamford Medical Society were resumed on October 10. The first meeting was addressed by Doctor C. C. Burlingame, psychiatrist-in-chief of the Hartford Retreat. His talk, "Hard Facts About Psychiatry", emphasized the interdependence of psychiatric problems and somatic diseases. The discussion was led by Francis M. Shockley and William B. Terhune.

The doctors of Stamford, having put away their golf clubs for the season, have turned to their winter pastime, bowling. Every Thursday afternoon finds them on the alleys, striving to improve their scores. The doctors' five-man team issues a defi to any medical group in the state for a match or series of matches.

Doctors D. Chester Brown of Danbury and J. Leonard Vickers of Greenwich are the representatives of Fairfield County on the Committee on Workman's Compensation of the State Medical Society. Any information, complaints, or problems which seem to any member to be important enough for consideration by this Committee should be sent to them.

Hartford

His many friends, colleagues and patients mourn the death of Doctor John F. Lynch, a member of the Surgical Staff of St. Francis Hospital. The sympathy of the County Association is herewith expressed to his wife and parents. In the relatively short time he had been in practice Doctor Lynch did a prodigious amount of work resulting in lasting good for numerous individuals.

Doctor Howard Mahorner, Assistant Professor of Surgery of Tulane University of New Orleans, Louisiana, addressed the Hartford Medical Society, Oct. 7. He dealt with "Surgery of the Peripheral Venous System" in a comprehensive way, considering all that was of practical importance in the etiology, pathology, physiology and treatment. His remarks were emphasized and augmented by the showing of many slides and by a moving picture. He dwelt at some length on the treatment of varicose veins and their complications.

On November 4, Doctor Richard Overholt of Boston will be the guest of the Hartford Medical Society when he will consider some problems of chest surgery. In the afternoon at 5 o'clock on this same date Doctor Overholt will conduct a clinic at the Hartford Hospital at which time some interesting chest cases will be presented for his consideration and discussion.

The annual fall outing of the members of the ex-internes and medical staffs of St. Francis Hospital was held at the Avon Country Club on Thursday, October 3. Some good and poor golf was demonstrated on this occasion and also some expert and inexpert pitching of quoits. The first prize golf handicap was won by Doctor John Winters. Doctors Louis Hastings and Peter Cenci were tied for low putts and another tie came about for low gross between Doctors James Hennessey and James Collins. Doctor Terry McNulty proved most efficient in throwing quoits. The affair was in charge of Doctor George A. Crawley and to his praise it may be stated that to date no one attending has declared himself to have had other than a very good time.

Doctor George Dunn of New Britain is the representative of Hartford County on the Committee on Workman's Compensation of the State Medical Society. Any information, complaints or problems which seem to any member to be important enough for consideration by this Committee should be sent to him.

Doctor Peter J. Steincrohn is to be congratulated on the publication by D. Appleton-Century Company of his book, "More Years For the Asking." It is a very readable little volume, full of information of value to the layman and should enjoy an extensive sale. The book will be reviewed in an early issue of the *Journal.*

* * * *

Litchfield

The Litchfield County Medical Society, following an old established custom, met on October 1 at the summer home of Doctor and Mrs. Harry B. Hanchett at Bantam Lake. This is the 17th year that this event has been held at Doctor and Mrs. Hanchett's. The president, Doctor Roy V. Sanderson, presided. The distinguished guests from other counties in the State who spoke briefly were: Doctors Otto G. Wiedman, Herbert Thoms, Samuel C. Harvey, B. Austin Cheney, James D. Gold, the Editor of the Connecticut State Medical Journal, Stanley B. Weld, and the Secretary of the State Medical Society, Creighton Barker. Elected to membership was Doctor Raymond D. Markle of Woodbury. The speaker of the evening was Doctor Francis G. Blake who discussed the use of sulphathiazole. Below is a brief resume of the salient features of Doctor Blake's talk:

ABSTRACT OF DISCUSSION ON SULFATHIAZOLE

By Francis G. Blake, M.D.

Sulfathiazole reaches its maximum concentration in the blood stream in about three hours after a single oral dose. For this reason its administration is continued day and night at four hour intervals. Sulfathiazole, like sulfanilamide, is rapidly excreted in the urine but is less soluble than sulfanilamide, and for this reason is much more apt to be deposited in crystalline form in the urinary tract. Unlike sulfapyridine, which is deposited in the pelvis and ureters, sulfathiazole is deposited in the tubules of the kidney itself. When this complication arises in the use of sulfapyridine, relief may be attained by irrigation of the pelves and ureters from below. When the complication occurs with the use of sulfathiazole, the forcing of fluids is indicated. In both instances obviously the use of the drug should be discontinued at once.

Diffusion of sulfanilamide in body fluids is greater than that observed with sulfapyridine and sulfathiazole. The diffusion of sulfanilamide into body fluids is about 95 per cent whereas with the two latter drugs it varies from 70 to 90 per cent. Sulfathiazole does not enter the spinal fluid, at least in the absence of meningitis, in sufficient concentration to be of therapeutic value locally.

As regards conversion into acetyl derivatives the following range of percentages usually occurs: — with sulfanilamide and sulfathiazole, 10 to 30 per cent, and with sulfapyridine 30 to 80 per cent. In order to determine this conversion in clinical use it is necessary to measure in the blood stream both the free and total amounts of the drug, the difference in these two levels being the amount of acetyl derivative. This is ordinarily important only in the case of sulfapyridine.

It has been found that for practical use the average adult patient confined to bed with an acute infection, should receive four grams as an initial dose, followed by one gram every four hours. This dosage applies to the three drugs, namely, sulfanilamide, sulfapyridine and sulfathiazole. Smaller doses should be used in the ambulatory treatment of gonorrhea. The greatest differences in blood levels with any of these drugs has been observed in the later decades of life. Obviously in such instances blood levels must be followed by frequent laboratory observations, particularly if there is impaired renal function or congestive heart failure.

The following complications and untoward reactions must be watched for and combatted with the appropriate measures:

1. Nausea, vomiting, vertigo and cyanosis although distressing to the patients, are of relatively little importance and do not contraindicate treatment. Acidosis is encountered only with sulfanilamide and is not at all common
2. The deposit of crystals in the tubules of the kidney in the case of sulfathiazole as contrasted with the deposit of crystals in the pelves and ureters in the use of sulfapyridine has been discussed above. With

sulfathiazole and also sulfapyridine the total output of urine should be carefully recorded from day to day. If oliguria occurs, administration of the drug must be promptly discontinued. Warning symptoms in the use of sulfapyridine are renal colic and hematuria.

3. Idiosyncrasies Acute hemolytic anemia has occurred in rare instances with sulfanilamide and sulfapryidine but has not occurred with the use of sulfathiazole. Scleral icterus is an early sign. Agranulocytosis has occurred in prolonged treatments with all three drugs. This has not been recorded, however, prior to the 14th day of treatment. Drug fever may occur with or without rash with all three drugs. The rash produced by sulfathiazole may resemble erythema nodosum. In the use of sulfathiazole, photophobia and conjunctivitis may occur from the fifth to the fourteenth day.

The original use of sulfanilamide proved its efficiency in infections from hemolytic streptococcus and gonococcus. The beneficial effects of sulfapyridine have been found equal to sulfanilamide in hemolytic streptococcus and meningococcus infections and this drug has proven more effective in pneumococcus and gonococcus infections. Sulfathiazole has been found to be as effective as sulfapyridine in streptococcus, meningococcus, pneumococcus and gonococcus infections. Sulfathiazole appears to be more effective in Friedlander's pneumonia, influenzal meningitis and particularly in staphylococcal infections. At the present time sulfanilamide is preferred in ordinary hemolytic streptococcus infections such as erysipelas, and meningococcal meningitis, sulfathiazole in the treatment of pneumococcus pneumonia and sulfathiazole or sulfapyridine in gonococcus infections.

Doctor Thomas J. Danaher had his appendix removed, at the Charlotte Hungerford Hospital on Saturday, October 12. He is making a satisfactory convalescence.

On October 21, was held the Annual Meeting of the Board of Governors of the Charlotte Hungerford Hospital. The president, Francis H. Griffiths, presided. Reports from the Chief of Staff, Department Heads, Treasurer, Director, Superintendent of Nurses, Dietitian, Housekeeper and Engineer were received. The Officers were elected for the ensuing year as well as the committees and staff members.

During the week ending October 12th, the City of Torrington celebrated its 200th anniversary. Represented among the floats was the Charlotte Hungerford Hospital Auxiliary, the central theme of which was the life of Charlotte Austin Hungerford. The Graduate Nurses Club was also represented by a float in the parade.

The Medical Draft Board for Harwinton, Goshen, Litchfield and Torrington is made up of the following physicians of the staff of the Charlotte Hungerford Hospital: Examiner — Harry B. Hanchett. Alternates — F. A. Weed of Torrington and John F. Kilgus of Litchfield.

Doctor Thomas J. Danaher of Torrington is the representative of Litchfield County on the Committee on Workman's Compensation of the State Medical Society. Any information, complaints, or problems which seem to any member to be important enough for consideration by this Committee should be sent to him.

Middlesex

The semi-annual meeting of the Middlesex County Medical Society was held at the Edgewood Country Club in Cromwell on Thursday, Oct. 10. Attendance was around 50, being better than average. Doctor Zimmerman of the Yale Medical School presented a most interesting paper on Neuropathology. At the conclusion of his paper many of the older members, in addition to praising it, expressed considerable surprise, for judging from previous meetings they had come to the conclusion that the human body contained only two organs, the thyroid and the gallbladder. After dinner Doctor Creighton Barker discussed the question of Medical Preparedness and outlined the mechanism of its application in Connecticut. This intricate subject was presented very clearly and held the attention of all of the members.

Through the good offices of Doctor William E. Wrang, the hospital sponsored a golf match at Edgewood Country Club on the afternoon of Sunday, Oct. 13. The competing players were Francis Quimet, former national open champion, and Tommy Gilligan of Boston versus Wallace Pierson, Jr., and William Zamoic, the Edgewood Country Club champion. Proceeds from the match were to be used for the purchase of an operating room light. While the returns are not yet all in, they will probably be in the neighborhood of $500.00.

On Wednesday, Oct. 9, at the annual meeting of the Middlesex Hospital staff, the following officers were elected for the ensuing year: President, G. M. Craig; Vice-President, Carl C. Harvey and Secretary, William M. Joyce.

There has been established at the Middlesex Hospital, under the direction of Doctor Carl C. Chase, a Department of Bronchoscopy and Esophagoscopy.

Doctor Benjamin Roccapriore of Middletown is the representative of Middlesex County on the Committee on Workman's Compensation of the State Medical Society. Any information, complaints, or problems which seem to any member to be important enough for consideration by this Committee should be sent to him.

* * * *

New Haven

Doctor John R. Paul, Yale University School of Medicine, at the recent meeting of the American Public Health Association held in Detroit, presented a paper on "Rheumatic Fever — Factors in Its Occurrence."

Doctors Frederick W. Roberts of New Haven, James D. McGaughey of Wallingford and Edward H. Kirschbaum of Waterbury are the representatives of New Haven County on the Committee on Workman's Compensation of the State Medical Society. Any information, complaints, or problems which seem to any member to be important enough for consideration by this Committee should be sent to them.

The New England Journal of Medicine (October 10) contains the report of a case of Weil's Disease in Connecticut with a discussion of its incidence in the United States, by Doctor Francis G. Blake, Sterling Professor of Medicine, Yale University School of Medicine.

Doctor Abraham Nowell Creadick, Associate Clinical Professor, Obstetrics and Gynecology, Yale University School of Medicine, was the guest speaker at the dinner of the Annual Fall Clinical Session of the Maine Medical Association held at Bangor on October 17 and 18.

New London

Doctor Charles Kaufmann of New London is the representative of New London County on the Committee on Workman's Compensation of the State Medical Society. Any information, complaints, or problems which seem to any member to be important enough for consideration by this Committee should be sent to him.

* * * *

Tolland

The regular semi-annual meeting of the Tolland County Medical Association was held at the Olde Homestead Inn, Somers, on Tuesday evening, Oct. 15. Presided over by Doctor Walter C. Haviland, Vice-president, in the absence of Doctor William Schneider, who is a larval electrocardiologist and in New York for a ten day's course. Following an appetizing and at the same time satiating dinner, the assemblence was addressed briefly by Doctor Arthur B. Landry, urging proselytizing of all eligible non-association members, and promising a discussion of the budget at the spring meeting. Doctor James R. Miller suggested the possible advisability of adapting the scale of state dues to conform to actual requirements, and of waiving dues of members who may be called into service. Doctor Charles C. Gildersleeve voiced greetings from New London County, as did Doctor William H. Upson from Hartford County, and Doctor Henry P. Talbot spoke for the desirability of purity in the ranks of our country's defenders, and of keeping venereal diseases under control. The speaker of the evening, Doctor George M. Smith, state chairman on Medical Preparedness, then took the floor and traced the evolution of National and State organization toward this end, and suggested following the progress in State and A.M.A. publications.

The County Association takes this opportunity to extend its congratulations to Doctor William L. Higgins of South Coventry, who started his practice on the first of May, 1890, and who celebrated his golden wedding anniversary Oct. 8.

Doctor E. H. Metcalf has been appointed examiner, and Doctors Roy Ferguson and John P. Hanley are alternates for the Tolland county board.

SPECIAL NOTICES

HISTORY SEMINAR

The Dawn of Anatomical Teaching

The Influence of the Great Artists and Printers of the Renaissance on the Evolution of Anatomy. The Anatomical Theater as the First Center of Practical Experimental Scientific Research.

Nov. 6.—6. Fabricius ab Aquapendente and his anatomical theater—the public lessons. The Nationes and the fight for freedom of teaching in the XVIIth century. The foreign students in Italy—Caius, Harvey, Pieter Paaw. Studies on physiology of circulation and of generation. The Renaissance in France and in England.

Nov. 13.—7. The first anatomical theater in Leyden. The theater of Copenhagen. The influence of the Renaissance on the northern school. The anatomical dissection in the paintings of the great Dutch masters. Their influence on the English school.

Nov. 20.—8. The beginning of the school of Bologna and the new conception of the anatomical theater. Marcello Malpighi and the dawn of experimental medicine. The last Galenistic anatomists.

*The seminars will be held at 4.30 P.M.in the Library of Physiology, B 105, Sterling Hall of Medicine, Yale University. They are open to all physicians who may care to attend.

—☆☆—

THOMAS WILLIAM SALMON MEMORIAL LECTURES

The Salmon Committee on Psychiatry and Mental Hygiene invites the medical profession and their friends to the Eighth Series of Thomas William Salmon Memorial Lectures to be given this year by Dr. Nolan D. C. Lewis, Director of the New York State Psychiatric Institute, and Professor of Psychiatry at Columbia University.

The Lectures will be given on successive Friday evenings, November 8, 15 and 22, at 8:30 p.m. at the New York Academy of Medicine, 2 East 103rd Street, New York City.

"THE PATHWAY OF RESEARCH IN PSYCHIATRY" will be the subject of Dr. Lewis' talks and subdivided as follows:

1. Historical Perspectives of Psychiatric Thought, an orientation discussion tracing the philosophic and prescientific endeavors and ancient scientific beginnings up to the 19th century.
2. Modern Ramification in Psychiatric Thought and Research, in which the leading psychiatric contributions and developments of the 19th and 20th century are discussed.
3. Prospects for Future Achievement in Psychiatric Research, in which a concept of future progress is tentatively formulated and in which certain leads in the direction of improvements in attitude and work are suggested.

Dr. Lewis is the author of many papers on neurological and psychiatric research, including "Constitutional Factors in Dementia Praecox", 1923, "Research in Dementia Praecox", 1936, and for several years has been field director of the survey conducted by the Scottish Rite Masons correlating and evaluating the research work now being done in dementia praecox.

* * * *

A. M. A. RADIO PROGRAM

DOCTORS AT WORK is the title of the sixth annual series of dramatized radio programs to be presented by the American Medical Association and the National Broadcasting Company.

The series will open Wednesday, November 13, 1940, and run for thirty consecutive weeks, closing with a broadcast from the A.M.A. meeting at Cleveland, on June 3, 1941. The program is scheduled for 10:30 P.M. Eastern Standard Time (9:30 Central; 8:30 Mountain; 7:30 Pacific time) over the Blue network, other NBC stations and Canadian stations.

The programs will dramatize what modern medicine offers the individual in the way of opportunities for better health and the more successful treatment of disease. Incidental to this main theme, the programs will explain the characteristics of the different fields of modern medicine and its specialties.

DOCTORS AT WORK, will be broadcast from scripts by Wm. J. Murphy, NBC script writer and author of many previous AMA-NBC "shows" and other popular radio features. It will be produced under the direction of J. Clinton Stanley, director of MEDICINE IN THE NEWS, last season's successful AMA-NBC health program. Supervision will be by the AMA Bureau of Health Education, directed by W. W. Bauer, M.D.

Descriptive posters for local distribution may be had gratis from the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago. Program titles will be announced weekly in *The Journal* of the *A.M.A.*and monthly in *Hygeia*, the Health Magazine.

* * * *

INDUSTRIAL PHYSICIANS AND EMPLOYERS TO CONVENE NOVEMBER 14

Industrial physicians and manufacturers from all over the country will attend the American Conference on Industrial Health to be held Thursday, November 14, at the Towers Club in Chicago. The conference will be sponsored by the American Association of Industrial Physicians and Surgeons, a 25-year old organization.

This first meeting of the American Conference on Industrial Health has for its purpose the correlation of viewpoints of all persons who are interested in promoting industrial health. These include the employer, physician, industrial hygienist, labor, psychiatrist, insurance companies, public relations men, safety expert, and the legal profession.

Dr. Clarence O. Sappington of Chicago, well-known consulting industrial hygienist, and co-chairman of the committee with Dr. Edward C. Holmblad, stated: "We have invited the manufacturer and other persons to attend and participate in the convention so that we may prove the practical value and application of industrial health work, and so that they may realize how much time and money may be saved yearly by such measures."

Among the prominent speakers who will talk at the convention sessions are: Dr. Morris Fishbein, editor of the American Medical Association Journal; Mr. B. C. Heacock, president of the Caterpillar Tractor Company of Peoria; Dr. Volney S. Cheney, medical director of Armour and Company; and J. M. Conway, representing the National Association of Manufacturers, New York.

The conference, which is scheduled to begin at 9:30 A.M., will conclude with a dinner session at which Dr. Fishbein and Mr. Conway will speak.

New England Postgraduate Assembly

November 13-14

The registration fee is $3.00. This does not include dinner and luncheons which will be served at reasonable rates. Applications for registration should be forwarded to the Post graduate Assembly Committee, 8 Fenway, Boston, Mass.

. . *Program* . .

WEDNESDAY, NOVEMBER 13

Morning Session

9:50 Assembly called to order by Dr. Frank R. Ober, Chairman, Executive Committee.

10:00 "The Practitioner and the Problems of Diabetes." Dr. Robert F. Loeb.

10:30 "Factors in the Production of Anemia." Dr. Russell L. Haden.

Intermission

11:15 "Treatment of Injuries of the Hand." Dr. Sumner L. Koch.

11:45 "The Medical and Surgical Management of Diverticulitis of the Colon." D. Henry W. Cave.

12:15 Luncheon (Memorial Hall).

Afternoon Session

2:00 "The Causes of Indigestion and Their Recognition." Dr. T. Grier Miller.

2:30 "Fungous Infections of the Skin." Dr. Oliver S. Ormsby.

3:00 "The Urinary Bladder in Health and Disease. Dr. Percy S. Pelouze.

Intermission

3:45 "The Management of Pre-eclampsia in Private Patients." Dr. Fred L. Adair.

4:15 "The Treatment of Respiratory Depression." Dr. Ralph M. Waters.

4:45 "Diagnosis and Treatment of Cancer of the Colon." Dr. Henry W. Cave.

6:30 Concert (Memorial Hall).

7:00 Dinner (Memorial Hall). Toastmaster, Dr. Reginald Fitz. Speaker, Dr. Harrison S. Martland, Newark, New Jersey—"Dr. Watson and Mr. Sherlock Holmes."

THURSDAY, NOVEMBER 14

Morning Session

9:00 "How May the General Practitioner Diagnose Cancer of the Cervix?" Dr. Fred L. Adair.

9:30 "The Relation of Anesthesia to Infant Morbidity." Dr. Ralph M. Waters.

10:00 "The Examination of the Nervous System." Dr. Tracy J. Putnam.

10:30 "Present-Day Concepts of the Management of Ulcerative Colitis." Dr. Henry W. Cave.

Intermission

11:15 "Precancerous Dermatoses." Dr. Oliver S. Ormsby.

11:45 "The Mechanism and Management of Diabetic Acidosis." Dr. Robert F. Loeb.

12:15 Luncheon (Memorial Hall). To be followed by a question period.

Afternoon Session

2:00 "Treatment of Acute Infections of the Hand." Dr. Sumner L. Koch.

2:30 "The Diagnosis and Treatment of the Convulsive State." Dr. Tracy J. Putnam.

3:00 "Present-Day Therapy of Gonococcal Infections." Dr. Percy S. Pelouze.

Intermission

3:45 "The Use of Liver and Iron in the Treatment of Anemia." Dr. Russell L. Haden.

4:15 "The Management of the Complications of Peptic Ulcer." Dr. T. Grier Miller.

HARRY BURR FERRIS
1865-1940
President, The Connecticut State Medical
Society, 1924-1925

CAT.

Harry Burr Ferris died in New Haven on October twelfth and Connecticut physicians, especially those with Yale training, mourn the passing of this quiet, friendly man who taught anatomy at Yale for more than forty years.

Doctor Ferris was seventy-five years old and from the time of his undergraduate days until he retired seven years ago his life has been a part of Yale and of New Haven. He graduated from Yale in the famous class of 1887, so many members of which were to achieve fame as he did with Wilbur Cross and "Billy" Phelps and "Bob" Corwin, names that will be remembered so long as there is a Yale.

Doctor Ferris was born in Greenwich, Connecticut on May 21, 1865, the son of Samuel Holmes and Mary Clark Ferris. He entered Yale at eighteen, distinguished himself by winning junior and senior high orations and by election to Phi Beta Kappa and rowing on his class crew.

After graduation he entered the medical school and received his degree cum laude in 1890. The following year Doctor Ferris commenced practice in New Haven and became an instructor in anatomy. Not long after he gave up his practice to give his entire time to teaching and was made the chairman of the department of anatomy in 1895 and E. K. Hunt professor two years later. For a while he taught forty-seven hours a week, with courses in anatomy and histology in the medical school and in anthropology in the graduate school.

Anatomy is rarely a popular course in the medical curriculum but "Pop" Ferris was an extremely popular teacher. In 1931 a large group of his former students and colleagues gave his portrait to the Ferris Room in the Sterling Hall of Medicine. The room is a library and seminar room for students of anatomy. When Doctor Ferris retired an anonymous donor endowed the Harry Burr Ferris lecturship in anatomy, and the school prize for high attainments in anatomy bears his name.

His contributions to the teaching of anatomy were no less brilliant than in the field of anthropology, a subject on whch he wrote extensively. He was the author of "Anthropological Studies of the Quicha and Machigauga Indians," "The Apurimac," and "The Indians of Cuzco." Occasionally he wrote medical biography and his monograph on "The Peregrinating Dr. William Tully, A.M., M.D." is a delightful narrative of the life of this whimsical Connecticut therapeutist.

Doctor Ferris was the President of The Connecticut State Medical Society in 1924-1925 and was a member of Phi Beta Kappa and Sigma Xi, the American Association of Anatomists, the American Society of Zoologists, the Association for the Advancement of Science and the Connecticut Academy of Arts and Science.

Creighton Barker, M.D.

☆☆

DANIEL ANDREW NOLAN, M.D.

1872-1940

Doctor Daniel Andrew Nolan, one of the oldest practitioners in Middlesex County, died at his home at 59 Park Place, Middletown, on August 3, 1940. He is survived by his widow of this city, and three sisters who are residents of Southington, Conn.

Doctor Nolan was born in Southington, Conn., January 14, 1872, the son of Martin and Mary Kane Nolan, both of whom were born in Cheshire, Conn.

After graduating from the Lewis High School at Southington he spent one year at a business college in New Haven, at the end of which time he entered the Philadelphia College of Pharmacy, being graduated from that institution in 1892 and receiving the degree of Ph.G. Three years later he received his M.D. degree from the Medico Chirurgical College at Philadelphia. He was registered to practice both medicine and pharmacy in the State of Connecticut. After serving as an interne for one year at the Samaritan Hospital in Philadelphia he began practice in Middletown.

Doctor Nolan had a leaning toward medicine, rather than surgery, and with no inclination toward specialization. He began and ended his career in medicine as a general practitioner, a family physician.

He was a member of the American Medical Association and its component societies. He was also a member of the Central Medical Society of Middletown. For many years he was the Secretary-Treasurer of the latter organization, holding that office at the time of the celebration of the sixtieth anniversary of the society, the outstanding event of its kind in medical circles in Middlesex County. By his personal efforts he contributed largely to the success of this affair. Doctor Nolan was not a politician, either medical or otherwise, but in 1911 he was elected President of the Middlesex County Medical Association at a time when there was as close harmony among the members of the medical profession in Middlesex County as ever existed.

Daniel Nolan was a particularly conscientious individual, never failing in the performance of a duty. It was this conscientiousness that prompted him, when our country was thrown into the World War, to volunteer for service in the medical department of the U. S. Army. He was assigned to Fort Oglethorpe, Ga., and later to Camp Hancock in the same state. At the latter place he was promoted to Captain and at the time of the Armistice had been recommended for promotion to Major. After the war Doctor Nolan helped to organize and was the first commander of the local American Legion Post.

In 1903 he was married to Miss Alice C.

Hennessey of Middletown. From this union two sons were born, twins, one of whom died in infancy, the other one passed on during the influenza epidemic of 1918 while the father was still in the army. The loss of these two children was a heavy blow to both parents, but they both displayed the highest type of Christian fortitude in their hours of adversity.

Doctor Nolan for a number of years was a member of the medical staff of the Middlesex Hospital. He was elected a Corporator for life in this institution in recognition of his services and his contributions to the hospital funds in the days when the hospital was most in need of financial assistance.

During all his residence in Middletown he was a worshiper at St. John's Roman Catholic Church. His long years of practice gave him a sympathetic understanding of other people. Experience taught him to see their virtues and to cover their faults with a mantle of charity. He was a man of high moral character, efficient and industrious. A resident of Middletown for nearly forty-five years he had endeared himself to all who knew him by his kindly spirit, his gentle and unassuming manner, and his unfailing courtesy.

James Murphy, M.D.

• Quarto Notes •

MANAGEMENT OF THE CARDIAC PATIENT

by

William G. Leamen, Jr., M.D., F.A.C.P., Assistant Professor in charge Department of Cardiology, Woman's Medical College of Pennsylvania

705 pages $6.50
Philadelphia J. B. Lippincott Co. 1940

The author, aware that the general practitioner is being separated more from the specialists by recent rapid advances in medicine and that he has little time to keep up adequately in all departments by reading original contributions, has prepared this text as an outline of the diagnosis and treatment in cardiac disease.

Realizing the purpose of the book it is of undoubted value. The presentation is clear, and confusion in the subject matter is largely eliminated by restressing the basic principles in each phase of the subject. Differences in opinion, particularly those of academic interest, are not allowed to confuse the reader; rather, the point of view which seems more workable and more generally accepted is included. The material is put to practical application with the presentation of case studies covering most of the situations seen in the practice of this phase of medicine. The text is illustrated with 255 figures and there is a good bibliography. The final chapter gives a clear introduction to the study of electrocardiography which should be of value in that it necessarily reviews the physiology of cardiac action.

P. Twaddle

New and Nonofficial Remedies, 1940, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1940

656 pages—LXVII $1.50
Chicago American Medical Association 1940

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January first is published in book form under the title of "New and Nonofficial Remedies." The book contains the descriptions proprietary mixtures if they have originality or other important qualities, important nonproprietary nonofficial articles, simple pharmaceutical preparations, and other articles which require retention in the book.

A list of articles and brands accepted by the Council, but not described, is included in the book to cover simple preparations or mixtures of official articles (U.S.P. or N.F.) marketed under descriptive, nonprietary names for which only established claims are made. Diagnostic reagents which are not used in or on the human body, and protein diagnostic preparations are not included in New and Nonofficial Remedies unless the determination of the status of these products by the Council has been requested by the distributor. If such products are found to be marketed in accordance with the Council's rules, they may be included in the list of undescribed, but acceptable articles.

New and Nonofficial Remedies is a practical and condensed text of pharmacology and therapeutics; it contains scientifically elaborated standards for all accepted nonofficial drugs; its Index to Distributors is a list of manufacturers, a large number of whose products have met the Council's high standards; its Bibliographical Index is a storehouse of references to reports which have been made mainly on unaccepted and unacceptable drugs; its prefatory material contains the Council's "Rules," a time-tested and reliable set of basic principles for the futherance of scientific and rational medicine.

A supplement to the annual volume of New and Nonofficial Remedies is published twice a year to bring up to date such current revisions and additions as have been necessary since its last publication. Every product included in the book is subject to the official rules of the Council. The comments to rules are changed occasionally by way of clarifying interpretations to insure fair consideration of all submitted preparations as new standards are recognized. Such constant and critical consideration of its contents provides the physician with a valuable reference list of acceptable new preparations on which to base his selection for use in treatment according to the established current practices of the profession.

The 1940 New and Nonofficial Remedies, of course, contains the revisions which appeared in the supplements for the 1939 edition, and continues the plan of grouping together articles having similar composition or action under a general discussion. These discussions have undergone considerable revision in the 1940 edition. Further revision of statements regarding the actions, uses, dosage, composition, purity, identity, strength or physical properties of many of the articles has also been necessary in some cases. Noteworthy revisions are those of the chapter on Liver and Stomach Preparations, radically rewritten and including a statement of requirements suggested by findings of the Anti-Anemia Preparations Advisory Board of the U.S. Pharmacopeia; the subsection Tuberculins, entirely rewritten to conform to newer knowledge in this field; and the chapter Allergenic Protein Preparations, the name of which has been changed to Allergenic Preparations. Minor but relatively important revisions are found in the articles: Bismuth Compounds, Serums and Vaccines, and Vitamins and Vitamin Preparations for Prophylactic and Therapeutic Use.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1939 with the Comments That Have Appeared in The Journal.

205 pages 5 illustrations $1.00
Chicago American Medical Association 1940

Only seven of the thirty-five reports listed in this annual collected report are of the familiar "Not Acceptable" or condemnatory type. Two reports announce omission of products from N. N. R., one being off the market. The remainder, far superior in bulk as well as in number, are concerned with educational and constructive considerations. This trend has been noticeable in recent years; it reflects the great predominance of the constructive over what may be called the destructive side of the Council's work of promoting rational therapeutics.

The educational reports touch three fields on which lie the front lines of present day therapeutics progress—chemotherapeutics, endocrines and vitamins. Two reports on sulfapyridine deal with the status and Council acceptance of commercial brands. The report on Neoprontosil recognizes that term as the Winthrop Chemical Company's proprietary name for 4-sulfonamide benzene-2-azo-1-hydroxy-7-acetylamino naphthalene-3: 6-disodium sulfonate, and azosulfamide as the nonprietary name for the same substance. The articles on Dilantin Sodium, Sobisminol Mass and Sobisminol Solution are status re-

Here, my young friends, have a stick of Chewing Gum.
Thank you, Doctor. Everyone in our family likes to chew gum.

How more and more Doctors are building good will the CHEWING GUM WAY

You naturally want children to feel that you are their friend. One sure, inexpensive way to gain their good will and friendship is to offer them a stick of wholesome Chewing Gum.

Today many physicians everywhere are using Chewing Gum as a good will builder in their offices. It's a delightful pastime that's beneficial and wholesome. Offer Chewing Gum to your young patients today.

The National Association of Chewing Gum Manufacturers, Rosebank, Staten Island, New York U-186

These are your Friends

ports which accompanied the descriptions of accepted brands, a type of article increasingly used by the Council. Dilantin sodium is the new drug used in the treatment of epilepsy and has been accepted by the Council with carefully stated limitations for its use; sobisminol mass and sobisminol solution are new soluble bismuth preparations for use in the treatment of syphilis; they are noteworthy in that sobisminol mass has been shown to be effective when used orally. The reports on racephedrine and nikethamide deal with nomenclature; these terms are recognized as nonproprietary names for racemic ephedrine (the sulfate and hydrochloride are also recognized) and pyridine-8-carboxylic acid diethylamide, respectively; the latter was introduced into medicine under the proprietary name Coramine-Ciba and was the subject of a preliminary report by the Council in 1929 (J.A.M.A., June 1, 1929, p. 1837).

The status report on questions concerning vitamins compiled by the Cooperative Committee on Vitamins of the Councils on Pharmacy and Chemistry and on Foods is becoming an almost annual event, awaited for the revisions of the "Allowable Claims" found acceptable for the various vitamins. This year's revisions are not extensive but the report is noteworthy for the reemphasis of the Council's stand on the subject of vitamins and vitamin mixtures. Alas, the Councils' is but one clear, authoritative voice of rationality in today's whirlwind of polyvitamin and polyvitamin-mineral absurdities foisted on the gullible public by astute and sophisticated advertising technic. The preliminary and supplementary reports by Snell and by Snell and Butt on the new principle for active hemorrhagic diathesis known as "vitamin K" are timely and noteworthy.

The leadership of the Council in matters of endocrine therapeutics and nomenclature is well sustained by such reports as Chorionic Gonadotropin, Assay Standards for Chorionic Gonadotropin, Stilbestrol and the Present Status of Testosterone Propionate: Three Brands, Perandren, Oreton and Neo-Hombreol Not Acceptable for N.N.R. No brand of any of these has been accepted and these reports are excellent justification of the Council's intelligent and well informed conservatism in this as in other matters.

Three "special" reports are worthy of mention. One is the warning report on the dosages of intra-urethral injection of solutions of local anesthetics, a reaffirmative strengthening of previous Council pronouncements. One is the Council statement Manganese in the Treatment of Dermatologic Disorders, which is buttressed by the conclusive and well documented paper of Dr. Maurice Sullivan, considered and sponsored by the Council. The third is the Study of the Promiscuous Use of the Barbiturates, Their Use in Suicides, a paper by Dr. W. E. Hambourger based on a review of medical literature and study of vital statistics. This study was authorized by the Board of Trustees of the A.M.A. and will be followed by other papers dealing with other aspects of the problem.

The present annual volume of Council reports is somewhat larger than usual and somewhat above the average issue in interest.

COPYRIGHT 1939, THE COCA-COLA COMPANY

Give them the first chance

Only One in Ten Knows These Facts . . .

ABOUT EYES

Question:—*Whose advice should I first seek concerning my eyes?*

Answer:—Your Family Physician's.

Q.—*Who will the Family Physician recommend?*

A.—Your Family Physician will recommend an Eye Physician (medical doctor).

Q.—*Why an Eye Physician. (M.D.)?*

A.—Because the Eye Physician with his medical training knows the eye in its relation to the body. He can determine whether headaches, nervousness, etc., are due to eye trouble or have their origin elsewhere. When glasses are necessary he can prescribe them exactly for the corrective or relieving effect that is required.

Q.—*Who should fill my prescription for glasses?*

A.—Physicians recommend a Guild Optician — because the making and fitting of glasses calls for the skill of a master craftsman. When your glasses are made by a Guild Optician, you are sure that they will be exactly as your Eye Physician prescribed them.

ESTABLISHED 1890

THE Harvey & Lewis CO.

GUILDCRAFT OPTICIANS

With stores in . . .

Hartford **Bridgeport** **New Haven**
Springfield **New Britain** **Worcester**

MEDICAL NURSING

by

Edgar Hull, M.D., F.A.C.P., Clinical Professor of Medicine, Louisiana State University School of Medicine;
Christine Wright, R.N., B.S.;
Ann Eyl, B.S.
558 pages
Philadelphia F. A. Davis Co. 1940

This text book is well planned and the content is clearly expressed for the benefit of the student nurse. The Scope and Specialties of Internal Medicine are described in detail. The important medical diseases are discussed by a doctor, nursing care by a nurse, and a rather unusual feature is the dietetic management by a dietitian. There are fourteen units in which diseases of the Special Systems are discussed. The following are of special interest:—

Unit IX—Diseases of the Nervous System — which frequently are not included in a medical text book. These are briefly outlined and are important as many of these conditions are diagnosed on a Medical Ward.

Unit X—on Emotional Disturbances is a factor which has to be considered in relation to organic diseases.

Unit XI—deals with Nutritional Deficiency Diseases and here the dietary discussion is well outlined.

Unit XIII—includes Diseases Due to Allergy — Physica and Chemical Agents — which ordinarily are not described to any extent in this type of book.

Each unit has a correlated list of references which is convenient for the student and valuable to the instructor.

The illustrations are pertinent to the common as well as the unusual types of diseases. There is outstanding stimulation towards observation and interest in Medical Nursing apparent throughout the book. It is adequate for both class room and ward teaching. The outline on Nursing Care of Pneumonia is especially well done and could be followed for the study of other diseases.

F. E. Woodward

* * * *

PEDIATRIC SURGERY

by

Edward C. Brenner, A.B., M.D., F.A.C.S.
Associate Professor of Clinical Surgery, New York Post Graduate Medical School
843 pages $10.00
Philadelphia Lea and Febiger 1938

This volume consisting of 52 chapters is divided into 9 parts headed as follows: I. General Considerations, II. Cysts and Tumors, III. Diseases of the Osseous System, IV. Surgery of the Head, V. Surgery of the Neck, VI. the Thorax, VII. the Abdomen, VIII. Urologic Conditions and IX. Neurologic Surgery. All the surgical conditons of infancy and childhood are discussed except fractures, dislocations and other orthopedic conditions which the author states in his preface are well considered in numerous textbooks. The space alloted to the various diseases is in proportion to the occurrence and importance of these diseases. For instance, of the total of 791 pages of the actual text, 221 are devoted to the abdomen; 121, to urologic conditions; and 118, to the thorax.

Other outstanding men have made contributions to the text. The chapters on Anesthesia, Blood Transfusion and Congenital Cleft Lip and Palate have been written by Drs. Thomas D. Buchanan, Lester J. Unger and Harold S. Vaughan, respectively. Dr. Louis R. Davidson contributed Part VI, the Thorax; Drs. Clarence G. Bandler and Albert H. Milbert, Part VIII, Urologic Conditions; and Dr. John E. Scarff, Part IX, Neurologic Surgery.

There are numerous drawings and illustrations including X-rays which are clear and well described. There are no bibliographies but the table of contents and index are complete and thorough.

The form of each discussion follows the standard scheme of etiology, pathology, diagnosis, treatment and prognosis. The discussions are practical and direct and are not prolonged by unnecessary theoretical discussion.

This book does not contain anything startling or new that the pediatrician or the surgeon, doing general or pediatric surgery, does not already know, but it is useful for a reference book. It should prove particularly valuable to a general practitioner who sees sick children by enabling him to know what diseases are amenable to surgical treatment and the results that may be obtained by such treatment. The chapters on appendicitis and peritonitis are particularly well written. There is no discussion of the recent advances in chemotherapy in the various infectious diseases.

C. J. McCormack

* * * *

GONORRHEA IN THE MALE AND FEMALE
A Book for Practitioners

by

P. S. Pelouze, M.D.

471 pages
Philadelphia and London W. B. Saunders Co 1939

In the latest addition of his famous monograph, Dr. Pelouze continues to lay stress on the anatomy and histology of the male genital tract, on the pathology and clinical course of gonorrhea, and on the intrinsic defense processes normally present. In an analgous way, though somewhat less fully, the female genital tract is also reviewed.

New to the readers of previous additions, however, is the consideration of the more recently developed agents of therapy. Sulfanilamide and allied preparations in their effect on the clinical course of the disease, on criteria of cure, and on transmission of the disease are admirably discussed. Hyperthermia is briefly alluded to and its danger quite justifiably mentioned. Theelin is also described in relation to vaginitis.

D. W. Byrne

For Non-Professional Visiting Hours

When the visitors are friends, introduce the Scotch that wins a warm reception—mellow Johnnie Walker.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE
Wyeth
is indicated in the treatment of

★ Acute Anterior Urethritis (due to Neisseria gonorrheae)
★ Trichomonas Vaginalis Vaginitis
★ Vaginal Moniliasis
★ Bartholinitis and Skeneitis (due to Trichomonas Vaginalis)

Silver Picrate is a definite crystalline compound of silver and picric acid. Available in the form of crystals and soluble trituration for the preparation of solutions; suppositories; water-soluble jelly; and powder for insufflation.

Complete information mailed on request

★ **JOHN WYETH & BROTHER, INCORPORATED** ★
PHILADELPHIA, PA.

• Abstract •

A METHOD OF NUTRITIONAL PROTECTION DURING SENESCENCE*

During senescence, many conditions are prevalent which tend to prevent the adequate utilization of a well balanced diet. Degenerative processes, voluntary or required dietary restrictions and organic disease, especially if it occurs in the gastrointestinal tract, all play an important role in interfering with proper digestion, absorption and assimilation. In this manner, they pave the way for nutritional deficiency states.

It is generally recognized that an adequate, energy-producing and nutritional protective diet is an essential requirement during old age. However, since an ample dietary regimen is usually not well tolerated by this type of individual, a fortified food drink was used as a supplement to their regular therapy. The purpose of this supplementary feeding was two-fold; first to supply essential vitamin mineral elements and secondarily, by using it as a flavoring agent to act as an incentive to these individuals to drink the required amounts of milk.

Thirty senile individuals having a variety of gastrointestinal disturbances were given Cocomalt as a food drink. It was found that the product was well liked, well tolerated and did not cause any aggravation of their symptoms. In most instances, during one month of observation, there was an improvement in the red blood cell count and percent hemoglobin, an increase in appetite and a moderate gain in weight. It was found that the ability to tolerate milk was greatly enhanced by its use.

In conclusion, it may be said that the fortified food drink (Cocomalt) by itself may have limited therapeutic value. However, when used as a supplement to the regular necessary treatment, it is no doubt a valuable method in supplying essential vitamin-mineral elements in a pleasant form.

Harry Barowsky, M.D.

---

*From Medical Record — August 21, 1940.

LISTEN TO A FOETAL HEARTBEAT

— through the new "two-channel" Davol Stethoscope Tube. This modern tube will improve your present stethoscope. Latex for long life, heavy wall for durability and to exclude extraneous sounds, with length and weight just right to make it easy to carry and easy to use. One tube; twin channels. No obligation — want to try one? Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN:

Connecticut State Medical Society (1940-1941) . . . 4
Connecticut Hospital Association (1939-1940) . . . 5

ORIGINAL PAPERS:

Can Diabetes Be "Cured" by Early, Vigorous Treatment? — L. T. McDaniel, M.D., A. Marble, M.D., and E. P. Joslin, M.D., Boston, Mass. 710
Some Medico-Legal Problems . . . A. Frederick Mignone, Esq., New Haven, Conn. 719
Dissecting Aortic Aneurysm: Report of Two Cases — W. Holbrook Lowell, Jr., M.D., Hartford, Conn. 724
Early Days of the Fairfield County Medical Association — William M. Stahl, M.D., Danbury, Conn. 732
Common Sense in Psychiatry — . . . C. C. Burlingame, M.D., Hartford, Conn. 735
Child Guidance . . . George K. Pratt, M.D., New Haven, Conn. 739
Diseased Cervix As a Cause of Symptoms in Women — Harlan B. Perrins, M.D., New Haven, Conn. 741

CASE REPORT:

Pregnancy Complicated by Cancer of Cervix — Arthur H. Morse, M.D., New Haven, Conn. 743

EDITORIALS:

Get Off the Cracker Barrel . . . 745
Care of the Premature Infant . . . 746
The Preservation of Serviceable Hearing . . . 747
Connecticut Medical Examining Board . . . 748
Four Score and Ten — Plus Ten . . . 748

CLINICAL CONGRESS TO SPONSOR POSTGRADUATE COURSES . . . 750

FROM THE SECRETARY'S OFFICE . . . 752

SPECIAL MEETING OF THE HOUSE OF DELEGATES (Agenda) . . . 754

PROPOSED CHANGES CONNECTICUT MEDICAL PRACTICE ACT . . . 756

CONNECTICUT HOSPITAL ASSOCIATION . . . 760

LETTERS TO THE EDITOR . . . 763

THE DOCTOR'S OFFICE . . . 763

MEDICAL PREPAREDNESS . . . 764

NEW ENGLAND CONFERENCE ON TOMORROW'S CHILDREN — Caroline Ruutz-Rees, Greenwich, Conn. 768

THE GENERAL PRACTITIONER'S FORUM . . . 770

OUR NEIGHBORS . . . 771

NEWS FROM COUNTY ASSOCIATIONS . . . 771

NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE . . . 774

SPECIAL NOTICES . . . 775

OBITUARIES:

John Francis Lynch, M.D. . . . Edward J. Whalen, M.D. 776
Leo Wilson, M.D. . . . F. W. McFarland, M.D. and F. M. Bannon, M.D. 776

QUARTO NOTES (Book Reviews) . . . 779

"Do Unto Others—"

Eli Lilly and Company respects the physician's right to prescribe for the sick. Lilly products are advertised exclusively in the journals of the medical and allied professions, and every effort is made to reserve them for the doctor's prescription.

METYCAINE

(Gamma-[2-methyl-piperidino]-propyl Benzoate Hydrochloride, Lilly)

—An Adaptable Local Anesthetic

● Well-sustained anesthesia follows local infiltration or nerve block with 'Metycaine,' and prolonged anesthesia is a feature of its intraspinal use.

AMPOULES 'METYCAINE,' 1 or 2 percent, for infiltration anesthesia.

AMPOULES 'METYCAINE,' 10 percent, for spinal anesthesia, and 20 percent for nerve block. Must be diluted.

ELI LILLY AND COMPANY
Principal Offices and Laboratories
INDIANAPOLIS, INDIANA, U. S. A.

The Connecticut State Medical Journal

Vol. IV. DECEMBER, 1940 No. 12

Mid-Winter Dinner

Connecticut State Medical Society

FRANK H. LAHEY
BOSTON
President-Elect American Medical Association

"Some Economic Problems by a Non-Professing Economist"

THE LAWN CLUB
NEW HAVEN
7 O'CLOCK

Saturday, January 11, 1941

Can Diabetes Be "Cured" by Early, Vigorous Treatment?

L. TILLMAN McDANIEL, M.D.,
ALEXANDER MARBLE, M.D., and ELLIOTT P. JOSLIN, M.D.,
Boston, Mass.*

For experimental animals, the prevention of a certain type of diabetes (pituitary) has recently been demonstrated.[1],[2] Does this imply that in time one may expect the prevention, and perhaps the cure, of human diabetes? Concerning the knowledge of the prevention of the disease, from the viewpoint of heredity and the avoidance of obesity in relatives of diabetic persons, much has been said in the past and much information has been gained, but the newer knowledge affords a fresh, forward-looking approach to this important problem. During the past several years there have come with increasing frequency and significance reports of investigations in experimental diabetes by Houssay,[3] Evans,[4] Young,[5] Best,[1] Long,[6] Lukens,[2] and others. Certain of these studies bear directly upon the earlier work of F. M. Allen,[7] Copp and Barclay,[8] and others within the last thirty years, chiefly in the preinsulin era. It is the purpose of this paper to consider the possible application to human diabetes of the results thus obtained in animals.

Experimental Physiology and Pathology

It has long been known that pancreatectomy, sufficient to cause the production of diabetes in dogs, is accompanied by progressive degranulation and hydropic degeneration of the beta cells of the islands of Langerhans in the remaining pancreatic remnant, and that these changes are progressive if the animal is overfed, but are reversible if the animal is given insulin or fasted.[7],[8] In a sense, the significance of these evidences of a physiological overstrain of the beta cells was not fully appreciated until they were "re-discovered" in the experiments of recent years in which injections of anterior pituitary extracts were found to cause temporary or permanent diabetes in dogs, depending upon the number and amount of the injections.[5] Here again histological study gave evidence of progressive degranulation and hydropic degeneration of the beta cells, with recovery and restoration to normal provided the injections were not too long continued.[9] Evidences of regeneration in human pancreas had been noted previously, chiefly in the pancreases of diabetic individuals dying from acute toxic illnesses.[10]

Haist, Campbell and Best[1] showed that in depancreatized animals the remaining pancreatic remnant did not suffer a decrease in its normal insulin content in spite of the accompanying hydropic degeneration, unless enough tissue had been removed to produce diabetes, and in this situation the more extensive hydropic degeneration was accompanied by a low insulin content, suggesting that the remaining beta cells had been overtaxed and finally become exhausted. In the animals made diabetic by injections of anterior pituitary extract, assays showed a progressive fall in the insulin content of the pancreas. If the injections were too long continued, the beta cells were unable to regenerate and the remaining ones contained fewer granules. The animals were then permanently diabetic. The Toronto group inferred that the permanent diabetic state resulted in large part from the final changes in the beta cells, as contrasted to the preliminary, reversible diabetic state in which the islet cell changes were transient.

These studies became particularly significant when it was discovered that the injection of insulin tended to prevent the reduction of the insulin content of the pancreas during the administration of pituitary extract, and that the degenerative changes were also prevented by fasting the dogs or by giving them high fat, low available carbohydrate diets. Furthermore, there was evidence that the cells of the duct epithelium of the pancreas were the parent cells of the islet and acinar cells because in some of the experiments vacuoles appeared in the duct cells as from proliferative exhaustion, and at other times mitotic figures were found. In the initial stages of pituitary injection there were proliferative changes in the islets of dog pancreases, and it had been observed that if insulin was given at the same time as the pituitary extract, the proliferative changes continued even though the degenerative changes were largely prevented. This latter observation was most important because it suggested that the earlier the insulin administration was begun, the more chance there was that the islands of Langerhans would remain intact.

---

*From the George F. Baker Clinic, New England Deaconess Hospital, Boston.

Haist, Campbell and Best[1] found that fasting or fat-feeding brought about a reduction in the insulin content of rat pancreas, whereas a diet of sugar tended to prevent such a fall. In fasting animals, resumption of a normal diet resulted in a return to the normal insulin content of the pancreas, the use of a sugar diet caused an unsustained rise to normal, but a fat diet resulted in the production of an even lower insulin content. Insulin administration itself caused an even further reduction in the insulin content in fasting or fat fed animals. Thus insulin was shown not to prevent, but to increase the effect of fasting or fat feeding. All of these factors appeared to allow the islet cells to rest in their work of producing insulin, and therefore saved them from the danger of exhaustion from overwork or overactivity.

Finally, Lukens and Dohan[2] demonstrated that in a cat made unquestionably diabetic by partial pancreatectomy and injections of anterior pituitary extract, the diabetic condition could be cured by the administration of insulin, but the islet cells did not recover if the insulin had been too long delayed. This period in which the changes of hydropic degeneration are reversible, before the beta cells are completely destroyed, may last 3 to 4 months but as yet has not been definitely determined. For humans the time interval required for the development of diabetes is unknown. Incidentally, this time interval may be an explanation for the unusual manifestations of diabetes in acromegalics,[11] because the intermittent period of acute hyperpituitarism may not last long enough to bring about irreparable damage to the beta cells.

Outline of Present Study

So stimulating have been these reports from experimental laboratories that we have reexamined the records of certain of our diabetic patients, in the first place to discover any analogies between their course and that of experimental animals, and second, to see if any patients could be found who seemingly were cured or had benefitted by energetic treatment instituted soon after the onset of symptoms. Consequently, we have studied the records of those few patients in whom at post-mortem examination there were histological evidences of hydropic degeneration of the islet cells because this is the first pathological change found in dogs or cats made diabetic either by subtotal removal of the pancreas or by injection of anterior pituitary extract, particularly if the animal is subjected to the strain of a diet high in carbohydrate. As pointed out above, recent work has shown that in this stage of degeneration of islet tissue the process is reversible.

In addition to the cases showing hydropic degeneration, we have studied the records of those patients in whom the onset of diabetes was thought to be sudden, i.e., within less than 48 hours before diagnosis. It is in such patients, if ever, that one would expect vigorous treatment to reverse the pathological process, whether brought about by abnormal activity of the anterior pituitary or by excessive demands made on the beta cells as during infections.

1. Hydropic Degeneration

Cases showing hydropic degeneration of the islet cells are rare. Unlike laboratory animals, humans are rarely examined in the acute stages of their disease, and in the light of experimental studies, it would be expected that by the time humans reach the autopsy table the pancreas would exhibit only old, burned-out lesions. In Warren's[12] series of 486 autopsies, there were only 22 cases showing hydropic degeneration. Eight of these were patients from the George F. Baker Clinic, and since then one more has been added. Instructive cases are reported below. The presentation and comments assume that hydropic degeneration represents a stage in the development of human diabetes; whether or not such an assumption is valid remains for further study to establish.

Case 1305 was a boy aged 10.6 years when first observed in May 1917. There had been a gradual onset of diabetes the month before. There was no history of diabetes in relatives. For years he lived faithfully on a diet usually restricted to less than 25 grams of carbohydrate, and on some days when observed in the hospital he was fasted entirely. The protein content of the diet was rarely more than 60 grams, and the fat was never more than 110 grams, per day. He was one of the first patients to receive insulin, this being started on August 8, 1922. In those days of first trial when the unit strength was unknown, the insulin was given cautiously in small doses, but he was kept aglycosuric on a diet of carbohydrate 27, protein 43, and fat 105 grams a day. When at home the supply of insulin became temporarily exhausted, he was brought to the hospital in a moribund state on October 20, 1922, and in a few hours died in typical diabetic coma.

This case is important because it shows that 5½ years after the onset of diabetes and with treatment for the most part solely with a low carbohydrate diet, and 57 days after the institution of insulin in small doses, there were still present beta cells in the islands of Langerhans, which had remained active throughout those years until they were finally overcome by excessive strain. In the light of experimental studies it seems reasonable to suppose that the beta cells had been protected for years by the low carbohydrate diet.

Case 2967, a man aged 29.6 years when first observed in January 1923, had had a gradual onset of diabetes in May 1922. At this time there were no known relatives with diabetes although a few years later an uncle and this uncle's son developed the disease. On a restricted diet he became sugar free in the summer of 1922 and remained so for 3 months. In the hospital he again became sugar free on a restricted diet and the blood sugar became normal. When glycosuria again appeared he was placed on a diet of carbohydrate 54, protein 60, and fat 151 grams and 1815 calories with 18 units of insulin daily. He remained in good health, and for years kept the diabetic condition under control, requiring gradually increasing doses of insulin. He died in September 1935 in diabetic coma, following his first trip away from home in years.

As in the first case, this patient demonstrates that it must take years for all the beta cells to be destroyed, and that they may be protected by a restricted diet and administration of insulin. With the present knowledge, however, one would have started insulin immediately and coninued it, and would not have rested content with a sugar free urine and normal blood sugar values brought about by dietary restriction alone.

Case 4289, a Jewish woman aged 29.4 years, with no history of diabetes in relatives, is a very enlightening case. She was admitted December 7, 1924 with exophthalmic goiter, thyroid storm, and diabetic coma; the blood sugar was 0.54 per cent and the plasma CO_2 combining power was 11 vols. per cent. She had had no previous treatment, because glycosuria had been found only on December 6, and she had been aglycosuric the week before. She recovered from the coma, but remained very toxic from the hyperthyroidism so that operation could not be done. She then developed a labial abscess and died December 28 with septicemia and multiple abscesses.

This important case suggests the strain that the beta cells were under, chiefly from the hyperthyroidism, and finally by the addition of the severe acute infection.

Case 6270, an obese woman aged 65.9 years with no history of diabetes in relatives, with an indefinite onset of the disease in June 1927, was admitted to the New England Deaconess Hospital in August 1927 for regulation. There was prompt improvement and she was discharged on a diet of carbohydrate 98, protein 58, and fat 124 grams with 35 units of insulin daily. Since she remained sugar free after discharge, in May 1928 insulin was entirely omitted and blood sugar values remained normal for years. She remained on a restricted diet. At that time one might have considered the patient to be cured. Unfortunately, a tolerance test was not done. The last admission was on November 26, 1934, for treatment of an appendiceal abscess, at which time there was much glycosuria with blood sugar values at a mildly diabetic level. The abscess was incised and drained two days later. She was again started on insulin in small doses. The patient died December 3 from a pulmonary embolism, and at autopsy the abscess was found to be secondary to a carcinoma of the cecum.

One might conclude from this case that enough beta cells had been spared originally because of the prompt treatment of the diabetes at the onset of the disease, to maintain the patient at a normal state with only slight dietary restriction. The final severe infection, not preceded by insulin and its known protective action for the islets, was enough to bring about histological evidence of overstrain of the islet cells at death.

Case 6277, a woman of 50 years with no history of diabetes in relatives and with an indefinite onset of diabetes about a month before, was first observed in September 1927. She was not obese. In succeeding years insulin was taken only irregularly and she usually had high blood sugar values. No insulin had been taken for months prior to her last admission on April 17, 1933, but even then she required less than 30 units per day. She died May 16 of metastatic carcinoma of the stomach. The pancreas, including even the islet groups themselves, were involved by the tumor. Besides the hydropic degeneration some islets showed fibrosis, and the arteries were invaded.

In this case, was the final physiological overstrain of the remaining islet cells due to a choking off of a critical number of the few that had remained active in spite of the slow destruction in the previous years?

Case 6713, a woman aged 66.1 years, was admitted to the hospital February 25, 1928 with an infected toe. Glycosuria had been discovered in 1912. A sister and her mother's twin sister had diabetes. On March 3, 1928 the toe was amputated under spinal anesthesia. She required only small doses of insulin and it was omitted on the eleventh day after admission. She died of a coronary thrombosis 22 days after admission.

Except for the infection which seems hardly sufficient, one has difficulty in finding a cause for the hydropic degeneration in this elderly patient, unless so few islands remained after 16 years of diabetes that even the strain of a minor infection was enough to harm them.

Case 10760, a woman aged 66.5 years, with no history of diabetes in relatives, was first admitted to the hospital in January 1932 for amputation of her remaining leg. There had been an indefinite onset of diabetes about March 1928, and she had been on a diet without insulin since February 1931. At discharge from the hospital she was taking only 10 units of insulin daily. The patient was re-admitted April 9, 1933 with a blood sugar of 0.36 per cent and a CO_2 combining power of 32 vols. per cent. She was quite ill and febrile and died the following day from pneumonia

Here again, hydropic degeneration was observed in association with acute infection.

Case 11558, a woman aged 65.8 years, with no history of diabetes in relatives, was first observed in December 1932. She had never been obese. There had been an indefinite onset of diabetes about February 1932. She had not followed a restricted diet or taken insulin. She was frequently observed, and practically never required more than 30 units of insulin a day even on a diet containing 140 grams of carbohydrate daily. The patient died in March 1940 of pneumonia at the age of 73.

The findings at autopsy were remarkable. The pancreas was the smallest ever noted in any of our diabetic patients. It was "found only after considerable search and with great difficulty. Together with some of the peripancreatic fat which could not be safely dissected, the entire pancreas weighed not more than 12 grams." The microscopic observations were also significant in view of what has been found experimentally as regards proliferation of pancreatic duct cells. "Completely hyalinized islets are not rare, and many show early deposits of hyaline along the walls of islet capillaries. Occasional islets with fully developed hydropic degeneration of cells are also present. One focus of squamous metaplasia of epithelium of a larger duct."

It is remarkable that this patient did so well with so little islet tissue. Undoubtedly the terminal infection was responsible for the evidence of overstrain in the beta cells. In the presence of the last infection she was taking over 50 units of insulin daily and even then had high blood sugars and much glycosuria.

Case 11920, was a very obese man of 51.2 years with no history of diabetes in relatives. He was admitted on May 25, 1933 in diabetic coma and died about 13 hours later, after having had 405 units of insulin. He had had no insulin before admission, and the glycosuria had been discovered only three days before admission after he had had a head cold, polydipsia, and polyuria for three days.

The findings at autopsy were also remarkable. In addition to fibrosis and hydropic degeneration of the islands of Langerhans, there was "epidermidalization of ducts" which contained rare mitoses. The aorta showed syphilitic aortitis. A blood serological test had not been taken.

Comment

These cases appear to be explicable in the light of the recent experimental studies. As in animals, the islets seem to be affected by the physiological demands upon them, usually during periods of overwhelming infection. That diabetic patients lose their tolerance for carbohydrate and need more insulin during the time of infection is common knowledge. At such times the functional strain on the beta cells must be at its peak. Some cells are probably finally exhausted and die and hyalinization of the stroma occurs. Thus may one understand the increasing severity of diabetes in patients who control their disease poorly and suffer many infections. One infection may make a case of diabetes seem remarkably severe only briefly during a severe illness, but it must be in those patients suffering repeated insults that the diabetic condition really becomes constantly severe.

A patient illustrating the effect of a single severe infection was Case 17608, a man aged 49.2 years when first observed in October 1938. Glycosuria had been discovered in September 1937 but he had never had treatment. There was no history of diabetes in relatives. The patient was admitted to the hospital for treatment of a foot infection. A secondary streptococcus hemolyticus septicemia developed and he was treated with sulfanilamide. During the critical illness he required up to 166 units of insulin a day. After recovery he was aglycosuric on only 12 units of protamine zinc insulin daily and the fasting blood sugar was 0.14 per cent. Many similar cases have been observed. It is not unlikely that the beta cells in non-diabetic persons also undergo physiological overstrain during severe infections. That these do not develop diabetes possibly depends on the fact that they do not possess an inherited "diabetic anlage."

Warren[12] has already remarked that the infrequency of finding hydropic degeneration in his cases may be due to the large proportion of insulin treated cases, on the presumption that insulin reduces the functional strain and thereby the incidence of the lesion. More recently he has stated[13] that the infrequency of finding this lesion should be considered from the following points: (1) the lesion was relatively common in the pre-insulin days, (2) even the severe cases of sepsis and coma treated in the hospital have received large amounts of insulin prior to death, and (3) unusual care has been taken to rule out post-mortem change so that cases of false hydropic degeneration have been avoided.

2. Cases of Sudden Onset

Cases to fit this group are difficult to find. Obviously, those with onset of diabetes in the pre-insulin era must be excluded because, except for the protection of a low carbohydrate diet in a few cases, no insulin was available to exert its beneficial influence.

For years we have questioned each new patient and his relatives regarding the type of onset of diabetes. In the most recent group of a thousand new diabetics, the type of onset was sudden in 23, rapid (few days) in 36, gradual (weeks) in 136, indefinite in 789, and unspecified in 16 patients. The number of cases suitable for the present study has been limited even further, because in so many in whom there was a sudden onset, delay in seeing a physician for the institution of therapy was so prolonged that irreversible changes must have occurred in the pancreas. Finally, some patients had their preliminary treatment elsewhere and we could not be sure of their early response to treatment.

The development of human diabetes has been suspected to be due to endocrine influences in persons hereditarily predisposed to the condition. Consequently, in choosing cases for special study we have kept in mind not only the type of onset but also certain other characteristics, particularly those concerned with unusual activity in the endocrine glands other than the pancreas. Specifically, we have examined carefully the records of (1) children in whom diabetes was diagnosed in coma; (2) prepubertal and adolescent children; (3) women with onset of diabetes in pregnancy; and (4) women in whom the onset of diabetes was related to the menopause. In addition we have studied the case histories of a large series of (5) adult patients with sudden onset.

White[14] quite early remarked upon the evidences of excessive pitutitary secretion in children prior to the onset of diabetes. For other age periods the evidences of an endocrinal relationship are not as clear-cut.

Before going further it is essential to mention that long ago Naunyn[15] pointed out that early cases of diabetes treated promptly did quite well but that late or neglected cases did poorly. Physicians who have treated many diabetics have long recognized this fact. It is therefore obvious that the selected cases practically all show this prompt improvement, but the search is really for "cured" cases and not cases in whom the diabetes has been kept mild. Nevertheless, for a diabetic patient even amelioration of the disease is a valuable and happy occurrence.

1. *Children in Whom Diabetes was Diagnosed in Coma.* Since in young children particularly, diabetes is often rapid in onset and diagnosed when the child is in coma, it would be expected that these cases would have a favorable prognosis because the diabetes is treated early and vigorously. In the cases chosen for scrutiny we have seen *no* cures, and there have been none in whom there was an amelioration of the diabetic condition other than that which would be expected ordinarily with return to health after the bout of coma. It is possible that in many cases the advantage gained by early treatment was lost by careless control at home. In evaluating the progress of diabetic children, it is of course necessary to keep in mind that with increasing age and body size, larger and larger doses of insulin are required up to a certain point.

2. *Pre-pubertal and Adolescent Children.* During development children undoubtedly are subject to potent hormones from the anterior pituitary. Reference has already been made to the evidences of hyperpituitarism in certain children before the onset of diabetes. Certain facts emerge from our experience with diabetic children. We often note an apparent marked amelioration of the diabetic condition following initial vigorous treatment with a restricted diet and insulin; this suggests an analogy to the finding of Lukens and Dohan[2] that insulin treatment may "cure" the pituitary diabetes of cats if instituted before hydropic degeneration of islet cells has reached an irreversible stage. With diabetic children during the stage of marked improvement there is a great temptation to discontinue insulin. In the light of the recent studies, such a practice represents a grave error because within a period of weeks or months the diabetic condition reasserts itself in full force. With a child, once the diagnosis of diabetes is made, insulin should be given regularly even if only very small doses are required for control.

We will discuss briefly only two children whose course has been extraordinary. Their case histories are presented not because the marked amelioration of the diabetic condition can be attributed to early, energetic treatment, since in neither was the onset sudden nor the treatment unusual, but simply because of the fundamental questions raised by the unexpected response.

Case 4076 is most unusual. This girl, with a strongly positive family history of diabetes (known to be present in 16 relatives, among them the patient's maternal grandmother, possibly her father, and two cousins), was over-height and over-weight during the gradual onset of diabetes in December 1923. She took no insulin and came under our observation on September 8, 1924 when she was 8.5 years old. Glycosuria was controlled by diet until November 18, 1924 when she was started on insulin and regulated on 12 units daily. Gradually insulin had to be increased until it reached a peak of 65 units daily in 1929. Some months later she began to have frequent insulin reactions and started reducing the dosage herself in May 1935. By early October 1935 she was constantly aglycosuric, overeating her diet and taking only 8 units of insulin a day. Curiously enough, on October 30 she had acidosis with a blood sugar of 0.23 per cent and a CO_2 of 21 vols. per cent. She required 105 units of insulin in one day and was discharged 3 days later taking 70 units daily. Reactions again appeared and by December 20 she was taking only 4 units a day. Since March 1936 she has taken no insulin whatever and has had to have frequent meals in order to avoid hypoglycemic attacks. Nevertheless, some blood sugar values have been at a diabetic level and there has been glycosuria at times; other blood sugar values have been as low as 0.03 per cent. She eats frequently in order to prevent hypoglycemic attacks and has gained much weight. After extensive studies the best explanation that we can offer is that she is a diabetic who has developed a functioning adenoma of the beta cells. We have been unable to persuade her and her relatives to consent to an exploratory laparotomy.

Case 5351 is also most remarkable. This girl with no history of diabetes in relatives had a gradual onset of diabetes in October 1920 when she was 5.3 years old and overweight. Insulin was begun in October 1922 at her local hospital when she was in diabetic coma. The patient first came under our observation in July 1926 when she was 10.9 years old and was on a diet of carbohydrate 90, protein 55, and fat 85 grams with 60 units of insulin daily. There was no question about the diabetes. At one time she was taking a total of 72 units of insulin a day. In June 1936 she began to decrease the dosage because of frequent reactions, but she never omitted insulin or entirely neglected her diet. By April 1939 she was down to 8 units of insulin daily. Blood sugar values were normal and there was no glycosuria. A glucose tolerance curve at that time was very definitely diabetic in type, but she had been on a diet somewhat restricted in carbohydrate. Subsequently she took no insulin. Is this patient cured? Continued observation is essential.

3. *Women with Onset of Diabetes in Pregnancy.* There is no question that during pregnancy the material organism is profoundly influenced by the pituitary gland and by hormones from the corpus lutem, the placenta, and the thyroid. It is likely that these influences are sometimes not made manifest until after pregnancy, for then the whole endocrine system is still very active in re-establishing itself. Many women develop melituria during pregnancy and lactation. We have very few patients in whom diabetes appeared suddenly during pregnancy and among these there are no instances of amelioration of the disease by virtue of vigorous treatment. Indeed, in some diabetic women during the last trimester of pregnancy even more than the usual dose of insulin is required for maintenance. The increase in metabolism is one cause for this, but an endocrinological relationship may play some part.

4. *Women in Whom the Onset of Diabetes was Related to the Menopause.* Estrogenic preparations give relief to women who have menopausal symptoms because the estrogens are thought to inhibit the gonadotropic and lactogenic secretions of the anterior lobe of the pituitary. Clinical application of this knowledge, in the hope that the estrogens will also inhibit the diabetogenic hormone of the pituitary, has been tried in diabetic women in the post-menopausal state. Reports have been both favorable and unfavorable.[16],[17],[18]

It is well known that the highest incidence of developing diabetes is in the 40's and 50's and particularly from the ages of 45 to 55. There is a similar incidence in men in this age group. The common factors in etiology in these cases if that of obesity plus heredity. In women the presence of the menopause has never impressed us as being etiologically related to the onset of the diabetes. At these ages the onset of diabetes is much more insidious than in children. We have very few patients in this group who knew that the diabetes began suddenly. Other cases have been excluded because insulin therapy had been long delayed after the onset of diabetes.

5. *Adult Patients in General.* Since the

onset of diabetes usually occurs in adult life, there is therefore a wider selection of sudden onset cases from which to choose Many have been eliminated because data available are not sufficient to warrant conclusions and many others because after the discovery of diabetes insulin was withheld for periods of a few months to 10 or more years.

In a large group we have found only a few patients in whom improvement in the diabetic condition brought about by early vigorous treatment appeared to persist. Illustrative case histories follow.

Case 7578, a man without diabetes in relatives, suddenly developed the disease following an upper respiratory infection in January 1929 at the age of 47.5 years. He consulted us on February 2 when the blood sugar was 0.23 per cent and there was 4.8 per cent sugar in the urine. There was a prompt response to insulin and 2½ months later he was aglycosuric with an insulin dose of 13 units daily. By June he had given up insulin entirely and the blood sugar was normal. In March 1934 he was aglycosuric with a normal blood sugar, in spite of the fact he had gained weight. He died elsewhere in October 1935 of a pulmonary embolism. Unfortunately, there were no check-up tolerance tests.

Case 13713, a man with no diabetes in relatives, suddenly developed diabetes in May 1935 at the age of 69.9 years. A few days later when he was started on insulin, the blood sugar was 0.30 per cent one hour after a meal and there was 6.8 per cent sugar in the urine. There seemed to be only a moderate response to insulin and he was discharged on June 1 on 22 units daily, with a diet of carbohydrate 137, protein 71 and fat 89 grams a day. He reported on June 11 that urinary tests had been good, and he began to lower the insulin dose. He was checked every few months and was always aglycosuric with normal blood sugar values. Finally, after September 1936 the insulin which he had so constantly taken was omitted. He has taken no insulin since, eats freely, and remains sugar free by report in August 1940. The last blood sugar in August 1938 was normal.

Case 11976, a man with no diabetes in relatives, suddenly developed the disease in April 1933 at the age of 48.7 years, and first consulted us two months later. He had had no treatment, the fasting blood sugar was 0.31 per cent and there was 6.8 per cent glycosuria with acetonuria. He seemed to make only an average response to insulin and was discharged 11 days later on 30 units a day. The next month the patient's wife wrote of severe insulin reactions that the patient had suffered. In August 1940 the patient wrote that he had taken insulin for only about 2 years and the last time he had had sugar in the urine was about a year after he left the hospital. He did say that he was observing dietary restrictions.

Case 14814, was an obese man with no history of diabetes in relatives but who had had gout. He suddenly developed diabetes on July 12, 1936 at the age of 70.6 years. At his local hospital on July 28 the blood sugar was 0.40 per cent with much glycosuria, and he was started on insulin that day. He first consulted us on August 25 when he was taking 70 units of insulin daily. Urine tests began to show no more than a trace of sugar, and the blood sugar value dropped to normal, in spite of reductions in insulin dosage. After October 1936 he took no insulin but on November 18 the blood sugar was 0.21 per cent an hour after the ingestion of 50 grams of glucose. There have been observations every few months since then. Blood sugar values have been normal, only rarely has there been slight glycosuria, he eats freely and has remained obese.

Discussion

At the outset the results of the study may be summarized by stating that although no cures of diabetes can be claimed, in certain patients, early, vigorous treatment with either a restricted diet or insulin or both seems in retrospect to have brought about an amelioration in the diabetic condition of far greater degree than one would anticipate. However, many other patients, equally well treated, responded with only the expected amount of improvement.

Since there is no question that only a variable proportion of islet cells are undergoing physiological strain at any one time under certain conditions, undoubtedly if cases were reviewed in whom the onset of the diabetes had been "rapid" or "gradual" or even"indefinite", many cases would be found in whom proper treatment would give ample evidence of amelioration of the disease. A review of every case, even if details were complete, would be impracticable.

Haist, Campbell and Best[1] quite reasonably assume that the factors that prevent diabetes from occurring also tend to limit its progress. They state: "The procedures which permit the pancreatic islets to rest, namely, fasting, fat-feeding, and the administration of insulin, prevent or hinder the development of the diabetic state under experimental conditions. These procedures affect the pancreas in a manner opposite to that of high-carbohydrate diets, and prevent the deleterious effects of anterior-pituitary diabetogenic principles". A most important point is made by this group: "There is no evidence yet that the factors which rest the pancreas cause permanent damage to islet cells, whereas there is adequate proof that factors leading to overactivity may produce permanent changes." They also observe that though temporarily a resting or idle beta cell might be said not to be much better than an absent one, it is rest that "restores the cells and makes possible a better islet function in the future. The resting procedures, then, serve two purposes: they prevent the degenerative changes from occurring in cells not already affected; and they permit the restoration of those exhausted cells which still retain their ability to recover."

The preceding paragraph presents the crux of the whole problem. It suggests a logical basis for the Naunyn dictum that a severe diabetic carefully treated often does well whereas a mild diabetic if neglected does poorly. Some day we may know how long the beta cells in a human pancreas are able to stand excessive functional demands before reaching the point that they can no longer recover. Also, we may learn of degenerative factors other than infections and the diabetogenic hormone of the anterior pituitary. These other undiscovered factors may be much more frequent in occurrence and even more insidious in their action.

It is the duty of the clinician to employ with his diabetic patients the latest procedures known to be of benefit in the experimental disease, in addition to measures of established value clinically. By all means possible the doctor must shorten the interval between the onset of the disease and time of diagnosis, and the time between diagnosis and the beginning of treatment. The first period is the more difficult one with which to cope. Education of laymen, and particularly relatives of diabetic patients, is the most effective approach. The public must be educated in preventive medicine. Yearly physical and urinary examinations should be done, and companies which insist on regular, routine examination of their employees are doing them a kindness. All school children should have yearly examinations. Relatives of diabetics should be examined even more frequently and in addition should have periodic blood sugar tests. We have scarcely mentioned the well-known factors of obesity and heredity, but their importance should never be slighted or neglected.

Haist, Campbell and Best[1] suggest the possibility of a prophylactic administration of insulin and a low carbohydrate, high fat diet for large groups of potential diabetics (children of diabetic families). Unfortunately, such wholesale investigations are not practicable. We suggest that a feasible way to test the validity of the experimental findings is to start insulin treatment immediately on then ondiabetic twin of similar twins as soon as the diagnosis of diabetes is made on one of them, since the other invariably will develop the disease sooner or later. A second group of equal value in prophylactic treatment would be the children of conjugal diabetics.

These principles suggest an advantage of protamine zinc insulin which is not often mentioned, namely, that by its continuous release of active insulin it affords the constant effect of a protective mechanism. All children who have diabetes, no matter how mild, should take at least a small dose of protamine zinc insulin daily. The physician must see that this is done and should never waver in this decision because of the mildness of the case and the pleadings of the relatives and patient.

If one is tempted to treat a case with a sudden onset of diabetes with a very low carbohydrate, high fat diet, it must be remembered that such abnormal diets should not be too long continued. This is especially true in children if they are to develop normally. Finally, one must remember the pitfall into which so many people have fallen in the past, to their later sorrow. No matter how well a patient responds to the initial treatment, such a response is never the indication for a rapid reduction of insulin or of its entire omission, for the neglect of diet or for the toleration of the development of obesity. Diabetes is never "complete" until death itself occurs — there are always some functioning islet cells and to keep them in a functioning state should be a main goal of treatment.

If a patient with diabetes of recent and rapid onset should present himself today, we would immediately begin vigorous treatment, not only with insulin, but also with a low carbohydrate diet with the required calories made up in fat. However, if after a few weeks there seemed to be no significant amelioration of the disease we would increase the diet to one of moderate carbohydrate restriction, because by this time we could assume that all the beta cells which could recover had done so. However, we would be extremely slow to reduce the insulin dosage and diligent in its use with intermittent infections.

A diabetic should be taught to guard his islet tissue, as he does his toes and limbs. As always the intelligent diabetic, who is faithful to treatment, will prove to be the long-lived, happy diabetic.

REFERENCES

1. Haist, R.E., Campbell, J. and Best, C.H.: The Prevention of Diabetes, New Eng. J. Med., **223**, 607-615, (Oct. 17) 1940.

2. Lukens, F. D. W. and Dohan, F. C.: Morphological and Functional Recovery of the Pancreatic Islands in Diabetic Cats Treated with Insulin, Science, **92**, 222-223, (Sept. 6) 1940.

3. Houssay, B.A.: Carbohydrate Metabolism, New Eng. J. Med., **214**, 971-982, (May 14) 1936.

4. Evans, H. M., Meyer, K., Simpson, M.E. and Reichert, F. L.: Disturbance of Carbohydrate Metabolism in Normal Dogs Injected with the Hypophyseal Growth Hormone, Proc. Soc. Exper. Biol. and Med., **29**, 857-858 (April) 1932.

5. Young, F. G.: The Anterior Pituitary Gland and Diabetes Mellitus, New Eng. J. Med., **221**, 635-646, (Oct. 26) 1939.

6. Long, C. N. H.: The Influence of the Pituitary and Adrenal Glands upon Pancreatic Diabetes, Harvey Lectures (1936-37), **32**, 194-228, 1937.

7. Allen, F.M.; Studies Concerning Glycosuria and Diabetes, Cambridge (Mass.), Harvard Univ. Press, 1913.

8. Copp, E. F. F. and Barclay, A. J.: The Restoration of Hydropically Degenerated Cells of the Pancreatic Islands in Dogs under Insulin Treatment, J. Metab. Res., **4**, 445-451, 1923.

9. Richardson, K. C. and Young, F.G.: Histology of Diabetes Induced in Dogs by Injection of Anterior-pituitary Extracts, Lancet, **1**, 1098-1101 (May 14) 1938.

10. Warren, S. and Root, H.F.: The Pathology of Diabetes, with Special Reference to Pancreatic Regeneration, Am. J. Path., **1**, 415-430 (July) 1925.

11. Coggeshall, C. and Root, H. F.: Acromegaly and Diabetes Mellitus, Endocrinology, **26**, 1-25 (Jan.) 1940.

12. Warren, S.: The Pathology of Diabetes Mellitus, 2nd Ed., Philadelphia, Lea and Febiger, 1938, pp. 42-46.

13. Warren, S.: Personal communication.

14. White, P.: Potential Diabetic Child, Jour. Am. Med. Assoc., 88, 170-171 (Jan. 15) 1927.

15. Naunyn, B.: Der Diabetes Melitus, Vienna, Alfred Holder, 1906.

16. Collens, W. S., Slo-Bodkin, S. G., Rosenbliett, S. and Boas, L.C.: The Effect of Estrogenic Substance on Human Diabetes, Jour. Am. Med. Assoc., **106**, 678-682 (Feb. 29) 1936.

17. Gessler, C. J., Halstead, J.A. and Stetson, R.P.: Effect of Estrogenic Substances on the Blood Sugar of Female Diabetics After the Menopause, Jr. Clin. Invest., **18**, 715-722 (Nov.) 1939.

18. Spiegelman, A.R.: Influence of Estrogen on the Insulin Requirement of the Diabetic, Am. Jour. Med. Sci., **200**, 228-234 (August) 1940.

☆☆

HYPERTENSION AND DIABETES

Essential hypertension and diabetes mellitus resemble each other in so many respects as to suggest common etiological factors in many cases. The endocrine components appear to be pituitary, adrenals and thyroid. Low dosage irradiation applied to the pituitary and adrenal regions has been followed by symptomatic relief and a considerable reduction in blood pressure in most cases. In some this reduction in blood pressure has been a temporary affair which could not be maintained by subsequent treatments given when indicated by a rise in blood pressure. In many cases the symptoms did not recur when the blood pressure returned to the pretreatment level. A few cases of hypertension have been seen in association with pituitary and thyroid deficiency. In these the blood pressure returned to normal levels and symptoms were relieved following the administration of thyroid and extracts of the anterior and posterior lobes. In a small series of patients having both hypertension and diabetes the latter appears to have been greatly improved in about 50 per cent of the cases following irradiation of the pituitary and adrenal regions.

This form of therapy is an entirely safe procedure and can do no patient any harm if used in the dosage and by the method we have employed. It seems to possess sufficient promise to warrant careful investigation by other workers.

James H. Hutton, M.D.,
in Mississippi Doctor, June 1940

GOT A MATCH?

You don't need to have, to test for urine sugar with the new "Galatest" method, which dispenses with the need for bunsen burner and other laboratory equipment. A single drop of urine on a few grains of Galatest powder instantly reveals the presence or absence of sugar. You will like it, doctor, and so will your nurse and diabetic patients. Price? Fifty cents for approximately one-hundred tests. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

Some Medico-Legal Problems

A. FREDERICK MIGNONE, ESQ.,
New Haven, Conn.

The legal brethren have admired the tremendous strides the medical profession has made in the last quarter century. The status of the profession today is certainly a far cry from that described in the preamble to Henry the Eighth's statute granting the right to practice. Today we read with amusement the stricture of this preamble:

> "Foreasmuch as the Science & cunning of Physick and Surgery (to the perfect knowledge whereof be requisite both great Learning and ripe Experience) is daily within this Realm exercised by a great multitude of ignorant Persons . . . Common Artificers, such as Smiths, Weavers, and Women, boldly and accustomably take upon them great Cures, and things of great Difficulty, in which they partly use Sorcery and Witchcraft, partly apply such Medicines to the Disease as be very noxious and nothing meet, therefore, to the high displeasure of God, great Infamy to the Faculty, and the grievous Hurt, Damage and Destruction of many of the King's liege people, most especially them that cannot discern the uncunning from the cunning.".[1]

Despite the fact that today the average young doctor embarking upon a medical career is better prepared and equipped than at any time in the past there are still legal pitfalls which may arise to add to the trials and tribulations of medical practice. The malpractice action against a physician or surgeon is still the main irritant. Even though practically every practitioner today carries malpractice insurance as a sine qua non of practice, the mental disturbance, fear of impending judgment and disgrace, the upsetting of the keel of practice, still remain the concomitants of such an action.

It is interesting to learn that Connecticut has the distinction of having in its legal archives the first recorded case of a malpractice action. In 1793 a gentleman named Cross, resident of Stafford, brought an action against a Dr. Guthery[2] of the same town, claiming that,

> "On the 15th day of October in the year 1791 Martha Cross was afflicted with a scrofulous tumor in one of her breasts which required amputation, & the plff. applied to the Deft. to perform that operation, & the plff. says that the Deft. has for many years past been and still is a practising physician and professes to be well skilled in the art of medicine and surgery."

This apparently was the basis of the implied contract for treatment by Dr. Guthery.

The complaint continues to read

> "and the Deft. accordingly undertook sd. operation and amputated the Breast of the Wife of the plff. on said 15th Day of October, but the plff. says that the Deft. was wholly unfitted in the business of Surgery and totally destitute of the knowledge and Skill required to perform such operation & that the Deft. performed the same in the most Ignorant cruel and inhuman manner—contrary to the established & well known rules & principals of art in such cases, and the plff. says that the Deft. cut off the Breast of his wife & then laid on a plaster of lint without taking up any of the arteries or blood vessels and thus wound a sheet tight round her body & laid her on a bed. In which miserable situation she languished about three hours & then expired of the wounds inflicted by the cruel hand of the Deft."

The plaintiff caps an extended listing of the grievous wrongs he has suffered with the charge that the defendant doctor had thus

> "deprived him forever of her company, comfort and assistance & left him to bemoan her untimely fate destitute of the Blessings of Domestic Life"

all of

> "which is to the damage of One thousand pounds Lawful Money."

The case unfortunately developed into a dispute as to whether the plaintiff had accepted an offer of the defendant doctor to cancel his bill for services rendered in settlement of all claims.

The basic elements that go to make up the malpractice suit have not changed since Dr. Guthery's day. A concise summary of the essential factors entering into such an action is to be found in the following case note[3]:

> "Malpractice is professional misconduct or any reasonable lack of skill or fidelity in the per-

> formance of professional duties. The term as applies to physicians and surgeons means negligent acts committed in the treating of a patient, or the unskillful treatment, in consequence of which the patient is injured. It may either import improper treatment or culpable neglect of a patient. However, the term malpractice does include wilful acts and acts committed in ignorance.
>
> " . . . The relation need not be created by an express contract, and the fact that there was no contract in no way denies the existence of the relation. When a physician is called and the patient accepts treatment, such acceptance creates the relation of physician and patient. Upon undertaking the case the physician impliedly represents that he possesses that reasonable degree of skill and learning that is ordinarily possessed by physicians and surgeons in the locality where he practices, and which is ordinarily regarded as necessary to qualify him to engage in the business of practising medicine and surgery. And the law places upon him the duty of possessing and exercising that degree of skill and learning. But a physician is not chargeable with malpractice for failing to use his best skill and ability; he is not responsible for errors of judgment or mistake in matters of doubt. However, he must exercise that degree of care and skill imposed by the law, and if an injury results from his failure to exercise such care and skill he is liable. If a physician agrees to cure a patient and does not, he is not guilty of malpractice unless he is negligent, and whether there is an ultimate cure is immaterial. In order that the patient may recover in action of malpractice against a physician or surgeon he must show: (1) that the relation of physician and patient existed between him and the defendant at the time of the alleged malpractice; (2) the treatment or lack of treatment; (3) that said treatment or lack of treatment is not regarded as proper by those skilled in the profession practicing in the same locality as the defendant; (4) that the injury or death caused by the malpractice resulted as the proximate result of such treatment or lack of treatment. A country surgeon should not be expected to exercise the high degree of skill possessed by eminent physicians practicing in large cities who are specialists. The breach of the relation of physician and patient occurs when the physician commits an act of negligence or fails to exercise that degree of care and skill imposed by law. The right of action depends upon the continuing or intervening conditions caused by the physician's neglect of his duties."

The Statute of Limitations restricting the time within which a malpractice action can be brought begins to run when the negligent act is committed.

In the extreme case where there is "obvious gross want of care and skill," negligence on the part of the physician can be inferred on the basis of the legal doctrine of "res ipsa loquitur" (the thing speaks for itself).[4] In such a situation a prima facie case of negligence is made out against the physician from the facts alleged and purporting to sustain the legal conclusion of "obvious gross want of care and skill." Such a prima facie case, however, rests on a rebuttable presumption of evidence — which means that the physician in making out his defense must explain away the factual situation upon which the plaintiff makes his claim of "res ipsa loquitur". If the defendant physician succeeds in doing this the plaintiff is then required to prove the allegations of his complaint by a preponderance of the evidence in order to prevail—just as he must do in the ordinary malpractice or other civil action.

This is an age of accentuated medical specialization both in the fields of medicine and of surgery. Are there any essential differences in the bases of a malpractice action sustainable against the specialist? The answer is no—the only difference being that the standard of care is the higher one of the particular field in which the physician or surgeon holds himself forth to be a specialist. The legal situation as applicable to the specialist is aptly set forth in the leading case of Rann vs. Twitchell[5] which involved a malpractice action against an eye specialist. There the court brings out that,

> "One who holds himself out as a specialist in the treatment of a certain organ, injury, or disease, is bound to bring to the aid of one so employing him that degree of skill and knowledge which is ordinarily possessed by those who devote special study and attention to that particular organ, injury or disease, its diagnosis and treatment, in the same general locality, having regard to the state of scientific knowledge at the time. (cases cited). The duty of exercising this degree of skill attached to this defendant at the time of his employment and is the measure of his responsibility in the diagnosis of the case to determine the nature and condition of the injury, as well as the proper treatment to be applied. (cases cited). He is not to be judged by the result, nor is he to be held liable for an error of judgment. His negligence is to be determined by reference to the pertinent facts existing at the time of his examination and treatment, of which he knew, or in the exercise of due care should have known."

An interesting question is posed in the situation where a general practitioner attempts to treat a disease or injury which in accepted medical standards would properly be held to be a case requiring the services of the specially trained specialist. Shall the general practitioner in such case be held accountable to the higher standard of the specialist? It is a matter yet to be subjected to a legal determination — which unquestionably would have to take into consideration such primary factors as to whether an emergency existed, the nature of the disease or injury, the training of the practitioner, whether the handling of such injury or disease in accepted medical practice is properly only to be treated by an expert in that field — the so-called specialist.

The tremendous advances made in methods of treatment employing the utilization of new and improved instruments and appliances have created further medico-legal problems. Can the physician delegate to non-medical assistants the operation of such appliances or instruments? It is of course elementary to point out that any touching of the person whether it be by operation or by the use of appliances upon the body is technically an assault and battery regardless of success or actual benefits derived therefrom. Such a battery is only excused where there is express or implied consent granted by the patient. The sole exception is that of an emergency where a patient's life is actually in danger. It must further be kept in mind that the right to practice medicine and surgery is not a fundamental right. It is rather a privilege granted by the constituted state authority. Fortunately the standards upon which our own state grants a license to exercise such privilege are exacting — as the so-called "diploma mill" scandal cases in the late twenties emphasized. The physician or surgeon, in the exercise of the privilege to practice, can not delegate to an agent the performance of an act the right to perform which has been acquired solely by virtue of such license. He is responsible for the negligent acts of an employee or servant performed during and within the scope of the employment.[6]

Another aspect of medical practice which is of importance, especially from the legal viewpoint, is that of the privileged communications between physician and patient. Professor Wigmore, the great authority on the law of evidence, points out that at "Common Law confidences of a patient to a physician were not privileged"[7] In this country such a privilege was first granted in New York State by a statute of 1824, which served as a model for similar statutes subsequently adopted in about one half our jurisdictions. The theory behind these enactments is that the safeguard of confidential privilege would induce a patient to reveal facts the knowledge of which might be essential to effect a cure — revelations which unless wrapped in the protective coating of the physician's pledge of secrecy the patient supposedly would not make. There has been a sharp clash of opinion as to the necessity and advisability of such a privilege. Professor Wignore, for example, is outspokenly critical of the necessity or value of the rule. With this background of the privilege rule it is interesting to note that our own state of Connecticut has never enacted a privilege statute.

> "In this State, information acquired by physicians in their professional capacity has never been privileged. Sherman v. Sherman, 1 Root 486. It was not so privileged at Common Law. Duchess of Kingston's Trial 20 How. St. Tr. 355, 573. This rule still prevails where it has not been changed by statute, as it has in many states but not in Connecticut. 70 C.J. 439."

Zeiner v. Zeiner, 120 Conn. 161, 167 (1935). Accordingly, in this state the physician, if called to testify as a witness, cannot plead the protection of such a statute.[8]

With the advent of the automobile and of workmen's compensation, the cooperation of the physician or surgeon in helping the lawyer establish his case has become vital. The testimony of the doctor as to the nature and extent of injuries received is a most important factor in the assessment of damages. This is a field often fraught with disagreeable tinges. There is a small minority in the ranks of both medical and legal practitioners who are unscrupulous in their attempts to build up and inflate the medical injuries and medical bills. Just because an insurance company may be in the background to foot the bills does not excuse unethical conduct of this sort. The doctor, like the lawyer, is entitled to fair compensation for the services he renders, but the deliberate padding of bills, or the rendering of entirely unnecessary and repititious services for the sole purpose of "boosting the kitty" are not within the bounds of professional ethics. And in fairness it must be added that more often than not a lawyer is to blame for suggesting such tricks to the doctor in order to magnify the seriousness of the case. It is a problem requiring close cooperation between the representative groups of the bar and the doctors to force the few in both professions to respect and live up to the higher ethics of the professions as a whole.

The average doctor usually abhors the idea of going into court to be a witness. It oftens means a considerable loss of time following the vagaries of the average law suit in getting reached for trial. The doctor, none the less, is a vital witness and must appear when called. What is his position as a witness in court? He is of course in the class of the expert witness — one who has special knowledge in a particular field.

In a recent case decided by our Supreme Court[9] an interesting point was clarified as to the status of a physician who is called to testify in a case involving a patient whom he has attended. A dispute over a will centered on the mental capacity of the testator whom the physician had treated as his patient. This physician was called in as a witness by one side, and medical experts, basing their opinion on answers to facts assumed in hypothetical questions, were called in by the other. The court makes clear that the doctors called in to testify as experts, without personal observation or examination of the plaintiff, testify only as persons having special knowledge and skill in the profession. The court definitely brings out that the physician who treated the patient testifies as a medical expert whose testimony is entitled not only to the weight which the physician's own position and standing in the profession compels, but also to the weight ordinarily attaching to the opinion of an attending physician who has had "special opportunity for skilled observation."

To put it more concisely, the court clearly implies that the testimony of a doctor who treated the plaintiff or defendant in a case can testify not only as an expert, but in addition, on the basis of personal observation his testimony is entitled to greater weight than that of an expert who formulates an opinion based on hypothetical questions only.

In bringing to a conclusion this limited discussion of some medico-legal problems the recent decision of our Connecticut Supreme Court in the so-called birth control case[10] is worth a brief review. In that case each of two physicians was charged with a criminal information that as

> "a duly qualified and licensed physician, in violation of Sections 6246 and 6562 of the General Statutes, . . . assisted, abetted and counseled a married woman . . . to use a certain (specified) spermatocidal drug . . . and a (specified) contraceptive device . . . for the purpose of preventing conception for the reason that in the opinion of (the defendant) as a physician, the preservation of the general health of said married woman, who had sought his advice as a physician, required that she use said drug and device for the purpose of preventing conception, and 'that thereafter the said married woman in consequence of said conduct of (the defendant) did in fact use said drug and contraceptive device for (that) purpose.' "

The physicians so charged set up a defense, pleading by way of demurrer, that Section 6246, preventing the use of drugs or instruments to prevent conception, constituted

> " . . . an interference with the individual liberty of citizens and a deprivation thereof without due process of law violative of the federal and state constitutions, and, specifically, because it applies where a married woman makes use of such drugs, articles or instruments for the purpose of preventing conception (a) upon the recommendation and advice of a physician; upon such advice (b) 'under circumstances in which all physicians would agree that a pregnancy would jeopardize her life'; (c) 'where, for health reasons, the use thereof is necessary for such purpose'; (d) 'where such contraceptive measures are necessary to protect and procure the best possible state of health and well being'; also that the statute is unconstitutional if construed as being without an exception 'protecting the right of any physician to prescribe drugs, medicinal articles or instruments for the purpose of preventing conception.' "

The court states categorically that there is no ambiguity in the statutes in question and that therefore the implied limitation sought to be read into the statutes by the defendant physicians allowing them to prescribe for contraception, can not hold water. It bolsters its conclusion on this point by reviewing the continued legislative attempts to amend the existing statutes by having precisely such an exception added.

In analyzing this case it is important to note that the court makes a decided point of the fact that the facts of the case in question restrict the issue to situations where

> "the general health of a married woman requires the use of contraceptives."

It therefore rules out any decision on the question as to whether they would read an implied exception into the statutes in a case where

> "pregnancy would jeopardize life (ground (b) supra) similar to that usually expressly made in statutes concerning abortion."

The court makes reference to the decision of the Massachusetts Supreme Court in 1938 upholding the constitutionality of a similar statute as being unambiguous and without implied exceptions. The opinion points out that

> "Since 1873, when Congress passed an act (17 Stat. at Large (1873) 598, U.S.C.A., SS 334, 512) which included prohibition of the mailing or importation or furnishing of contraceptives, at least twenty-six states have passed laws relating to birth control. Of these, eight, including Connecticut and Massachusetts, attempt complete suppression; many prohibit publication of contraceptive information and advertisement of materials or offering advice or materials in any other manner; a few (including New York) contain exceptions which permit prescription under certain circumstances. There are only one or two states which have not, now, some form of statute regulating the distribution of obscene literature and 'articles of indecent use'."

In further substantiation of its decision the court cites cases illustrating the familiar legal principles

> ". . . that the exercise by states of the police power to conserve the public safety and welfare, including health and morals, may not be interfered with if it has a real and substantial relation to those objects; and that the Legislature is primarily the judge of the regulations required to that end and its police statutes may only be declared unconstitutional when they are arbitrary or unreasonable attempts to exercise its authority in the public interest. As was done in Jacobson v. Massachusetts, supra, 30, concerning a compulsory vaccination statute, we must assume that when the statute was passed the Legislature was not unaware of opposing views concerning contraception and deliberately chose between them; this is certainly true as to the recent repeated refusals to modify the statute by amendment."

The court also refuses to give any shrift to the assertion of the defendants

> ". . . that people have a natural right 'to decide whether or not they shall have children' and a concomitant right to use contraceptives if they decide not to have them."

It brings out that,

> "Conduct of the individual is subject to such direction and restraint as the public good requires."

The court then makes the reservation on its own part that,

> "Whatever may be our own opinion regarding the general subject, it is not for us to say that the Legislature might not reasonably hold that the artificial limitation of even legitimate childbearing would be inimical to the public welfare and, as well, that use of contraceptives, and assistance therein or tending thereto, would be injurious to public morals, ..."

It must be remembered, moreover, that the decision of the court was rendered by a majority of three of the five judges — two dissenting from the opinion rendered.

Following the pointed suggestion of this opinion that the remedy, if any is to be had, is in the General Assembly, not in the courts, it is interesting to note that already preparations are being made by the groups interested to secure public backing for an attempt to effect the statutory changes in the next session of the legislature.

REFERENCES

1. 76 Solicitor's Journal 569.
2. Reports of the Court of Common Pleas, Tolland County, Conn., for the year 1793.
3. 3 Detroit Law Review 204.
4. Frogge v. Shugrue, 126 Conn. 608, 613 (May 1940).
5. 82 Vt. 79, 71 A. 1045.
6. 49 Medico Legal Journal 85.
7. 3 Wigmore on Evidence Vol. VIII, Sec. 2380.
8. Sherman v. Sherman, 1 Root Conn. Reports, 486 affirmed the Common Law rule of no privilege as far back as 1792.
9. Jackson v. Walker, 126 Conn. 294 (March 1940).
10. State v. Nelson, 126 Conn. 412 (March 1940).

THOUSANDS HAVE SAID

"Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2)

Dissecting Aortic Aneurysm*

Report of Two Cases

W. HOLBROOK LOWELL, JR., M.D.,
Hartford, Conn.

One of the aims of modern medicine is accuracy of diagnosis and prognosis. We have in many instances no method of correlating or substantiating our clinical findings and observations, other than at autopsy and at operation. Too few verified cases, anatomically and physiologically speaking, are recorded. Nothwithstanding, diagnostic acumen has steadily become more concise and accurate with our modern methods of approach and study.

Since the classic paper by Herrick, 1912[1], the differential diagnosis of coronary occlusion, angina pectoris, and the acute surgical abdomen has become surprisingly less difficult. The recognition of massive pulmonary embolus with acute cor-pulmonale, which now comprises a large percentage of our sudden postoperative deaths, has been facilitated by the excellent review of Giertz and Crafoord, 1929[2]. It is amazing that as recently as 1937, McGeachy and Paullin[3] report, "It is, in truth a striking paradox that the most dramatic of all vascular accidents is seldom recognized antemortem, dissecting aneurysm of the aorta." In a recent case reported by Weiss, we find that the absence of coronary "T" waves may not be as important a differential point as they have been considered. Coronary compression by a dissecting aneurysm secondarily in rare instances can cause myocardial infarction; thus the electrocardiographic changes of coronary occlusion may be part of the picture.

The present study and discussion is the result of the author's observation of two sudden deaths on the medical wards of the Hartford Hospital. An attempt to re-emphasize and to stimulate interest in the study of dissecting aneurysm of the aorta is made: first, because of two physico-pathological findings, so prevalent in the general population, i.e. hypertension and arteriosclerosis or atherosclerosis, which in turn are attended by fatal consequences more often than are suspected; second, that such a study may aid in more accurate diagnosis and prognosis with present medical advance; and third, to record observation on the two reported cases.

A brief note on the history and the progress of study of the acute dissecting aortic aneurysm is given. A partial review of the English literature on the subject has been made, and the total number of cases and correct antemortem diagnosis is included. An analysis of all aortic aneurysms at the Hartford Hospital, verified by post-mortem examination, is given. Particular attention to dissecting aortic aneurysms of the acute type after the criteria of Glendy, Castleman, and White[4], i,e., those cases with the aneurysm directly related to death, is included. Tabulation and study of the reported cases from the electrocardiographic and the roentgenographic point of view are discussed briefly.

Nicholls 1762[5] reported his observations "on the body of His Late Majesty, George II of England." Morgagni 1796[6] and Manoir 1802[7] recognized dissection of the coats of the aorta as a pathological entity. Laennec 1819[8] is credited with the initial application of the term "aneurysma dessicans". Pennock 1838[9] reported the first cases in America. To Swaine 1855[10] is given the credit of making the first ante-mortem diagnosis. The first group-case study was made by Peacock 1863[11]. Since then excellent reviews have been published by Tyson[12], Shennan[13], Weiss[14], White et al[15], Glendy et al[1], McGeachy and Paullin[3] and Hamburger and Ferris[16]. The roentgenographic features of dissecting aortic aneurysm have been recorded by Wood, Pendergrass, and

---

*From the Medical Service of the Hartford Hospital, Hartford, Connecticut.

Ostrum[17]; dissecting aortic aneurysm simulating coronary thrombosis electrocardio-graphically by Elliot and Evans[18], White et al[15], and Weiss[19]. No tabulated analysis of the electrocardiographic findings has been found in the literature. McGeachy and Paullin[3] recorded the most frequent findings in a group of seventeen cases. A sign previously undescribed "an area of pulsation seen in the back moving laterally with the progress of the dissecting" has been recorded in a case report by Roesler, Gifford, and Betts[20]. Further direct evidence that syphilis makes dissection difficult and impossible is given by the case reported by Weiss[19] with localized aortitis and extensive dissection not involving the aortitis.

From this present study 638 cases of dissecting aneurysm of the aorta have been found reported in the literature with ante-mortem diagnosis made in 38. These figures include those cases in this report and one correct ante-mortem diagnosis. It would seem from such a study that there are many more unreported cases which in addition to the unverified sudden deaths, make the incidence higher than the figures indicate.

Glendy et al[4] report their incidence of dissecting aortic aneurysms as nineteen cases in eight thousand two hundred autopsies, or one in four hundred and thirty. Weiss[14] reported one in five hundred and forty. Our own series reveals an incidence of one in four hundred or seven cases in two thousand eight hundred autopsies.

From the total series of two thousand eight hundred and seventy-one post-mortem examinations performed in the Hartford Hospital from January 1926 to May 1939, twenty-eight examinations revealed aortic aneurysms. Table I consists of a listing of the aneurysms as recorded on the post-mortem protocols, with primary and secondary causes of death, and the incidental finding of aneurysm.

Because of marked overlapping, no attempt has been made to classify these aneurysms. They are, however, recorded in Table I as saccular, fusiform, dissecting and combinations of the three.

Aneurysm of the aorta was an incidental post-mortem finding in fourteen. Rupture or dissection of an aneurysm was found in fourteen, and was so listed as the primary cause of death. When further analyzed, rupture of a dissecting aneurysm as the primary cause of death may be attributed to seven. Incidental dissection, with but a slight degree of extension was found in seven cases. The dissection was observed as healed and recent. Death may be attributed directly to the aneurysm in five of the seven. There were three combined thoracic and abdominal dissecting aneurysms. There were two thoracic dissecting and one abdominal dissecting aneurysm found. The extreme incidence of age in all aneurysms was sixteen to eithty-four years, and in dissecting aneurysms it was thirty-seven to eighty years. Males predominated over females, seven to one. No dissecting aneurysm was found in the female. Arteriosclerosis and atherosclerosis with medial necrosis was the essential pathological finding. Syphilis as the pathological cause of aneurysm was noted in three cases, and coarctation of the aorta in one. In the group of seven cases in which we are concerned, the correct ante-mortem diagnosis was made in one. As above, the criteria for inclusion as an acute dissecting aneurysm are those offered by Glendy et al[4].

Since Swaine's[10] initial ante-mortem diagnosis many authors have published their observations, combined with the results of the more recent diagnostic procedures, primarily electrocardiographic and the roentgenographic interpretations. The clinical picture: with the sudden onset of severe tearing substernal pain or in the low mid-thoracic back, which does not radiate to the arms, but with progress goes to the abdomen, neck, lumbar region, and legs; syncope with aortic insufficiency and lack of pain, but with signs of increasing relative aortic insufficiency — Middleton and Porter[21], Resnick and Keefer[22] and Hamman[23]; history of a pre-existant hypertension with persistant elevation but for rare cases; inequality or obliteration of the peripheral pulses with the concomitant vascular changes secondary to ischemia and hematoma, which may clear with a complete return to normal of the circulation; evidence of visceral infarction with anuria and signs of intestinal obstruction and adynamic ileus; neurological signs and symptoms of hemiplegia, cerebral-aneurysm, all of which are more often than not transient; electrocardiographic evidence by serial tracings of changing coronary "T" waves, usually not pathognomic of coronary artery disease, but which may, in unusual cases, be typical of acute cardiac infarction — Weiss[19]; displacement of the trachea to the right with progressive increase in the mediastinal shadow, though difficult to demarcate — Middleton and Porter[21]; all have been helpful in making the diagnosis. Little has been said of the paradoxical pulse as a diagnostic point; present at onset or developing during progress of the condition. Between seventy and eighty per cent of these cases died from cardiac tamponade and should at some time have developed this sign. This necessarily may be applied only to those cases which develop cardiac tamponade slowly. Such was the situation in our second case. Consideration of the above clinical points and diagnostic criteria, as the basis of differential interpretation, may make recognition of the existent physio-pathological processes easier.

There is apparently no one sign or symptom which is pathognomic of the condition, but when each is taken and correlated as a whole, accurate diagnosis is materially aided.

Recent observations that the common conception of the mode of onset of the acute dissecting aortic aneurysm, may not be a sudden dramatic event initiated by unbearable pain, is emphasized in one of the reported cases. The same notation is made by Hamburger and Ferris[16] in four of their cases, and re-emphasized in the discussion of Middleton and Porter[21] Further evidence to support this is offered in the fact that eighty percent of these cases rupture into the pericardial cavity and produce a high degree of relative aortic insufficiency. Secondly, sudden unconsciousness may prevent the appreciation of pain. One of the presented cases upon recovery complained of no pain. These points should be considered in the differential discussion. The presence of hypertension is not as important a sign as previously described, as has been observed by the above authors. This point is re-emphasized in one of the reported cases to follow.

According to McGeachy and Paullin[3], as previously noted, seventeen cases with electrocardiographic tracings had been recorded. Tabulations according to the frequency of incidence of changes have been made in thirty cases in this study. Lack of unequivocal "T" waves and left axis deviation, would seem to be the most useful findings. The interpretation of myocardial damage suggestive of coronary disease, but not pathognomic should, however, always connote skepticism and make one suspicious of atypical coronary disease. This is born out in the two reported cases and in the case of Weiss[19], supported by tracings before and after the onset, which showed definite evidence of cardiac infarction and was substantiated at post-mortem. A case of Glendy et al[1] showed changes in Lead I and II consistent with infarction of the posterior or diaphragmatic type. Support that these changes were the result of cardiac damage was born out in the finding at post-mortem of dissection to the opening of the right coronary artery.

Wood, Pendergrass and Ostrum[17] report the x-ray findings as an arcuate excrescence from a point in the thoracic aorta or arch with or without pulsation. With the extension of the dissection an increasing shadow along the vessels of the aortic arch may be present. Other findings have been eosophageal and trachial displacement, cardiac, enlargement, bizzare densities in non-fatal ruptures into the periaortic tissues and evidence of fluids in the left pleural cavity. Middleton and Porter[21] are a little more specific in the description of the arcuate excrescence. It may appear as a double contour of lesser and greater density seen on the upper right and lateral left superior mediastinum. There are many cases, however, which by x-ray show only cardiac enlargement in the region of the left ventricle and present no change which may help in the diagnosis. There is thus no single pathognomic roentgenographic finding.

The following conditions have been considered in the differential diagnosis of acute dissecting aortic aneurysm, re-emphasizing the previously existing confusion as to its recognition. Cognizance of this should reveal the need for its inclusion in the differential diagnosis of any acute cardio-vascular accident: coronary occlusion with cardiac infarction remains foremost, cerebral aneurysm, cerebral hemorrhage or thrombosis, spontaneous pneumothorax, pulmonary embolism, the acute abdomen, uremia, Stokes-Adams Syndrome, traumatic dissecting aneurysm, coarctation of the aorta, acute pericarditis, interlobar or diaphragmatic pleuritis.

Table II is a tabulation of the presenting symptoms, heart examination, blood pressure observations, history, neurological and circulatory changes, with the provisional diagnosis and the type of death in our seven cases.

From three-quarters to four-fifths of these cases terminate fatally in the course of several minutes to several days. They usually rupture through the adventitia causing hemo-pericardium, left sided hemothorax, mediastinal extravasation or retro-peritoneal hemorrhage. Rare cases of re-rupture through the intima causing a double barreled aorta have been reported. From this study it seems fair to say that incidental slight dissection occurs more frequently than has been reported.

CASE REPORTS

Case No. 1.—J. G.—Hartford Hospital No. 359-599, a fifty year old, Canadian-born parts worker in a typewriter factory, was admitted September 24, 1938, to the general surgical service with the chief complaint of epigastric pain of thirty-six hours duration.

The patient was a known hypertensive. Appendectomy had been performed in another hospital in 1915.

Past history, family history, social history and further unit history were irrelevant other than as noted.

Thirty-six hours prior to admission, while at his work carrying a forty-pound weight in his arms, he was suddenly seized with a knife-like pain at the tip of his right scapula. It was severe enough to take his breath away, and followed by a feeling of faintness and generalized weakness. He discontinued his work and took to his bed. About six hours following the onset, the pain appeared in his mid-epigastrium extending down the costal margin on the left, and into the mesial portion of his left thigh with a feeling of numbness in the left leg. He was unable to lie on his left side and unable to hyperextend his back or legs without extreme pain in his epigastrium. He vomited twice, eight hours prior to admission. He was able to walk into the hospital in a stooped-over position.

Physical examination showed a middle-aged man, seemingly older than his stated age, lying in a doubled-up position on his right side with both thighs flexed, with moderate dull pain in the epigastrium radiating into the left iliac fossa and leg with a feeling of numbness in the same. The left pupil was larger than the right but was regular and reacted to light and accommodation. Retinal examination showed marked arterio-sclerotic changes. The routine chest examination was negative. There was moderate pallor and an icteric tinge to the skin and sclera. P.M.I. was noted to be in the anterior axillary line. Sounds were of fair quality. No rub or murmur was heard. Radial and apex rate the same, radials bilaterally regular and forceful at eighty per minute. Peripheral vessels were markedly sclerotic and a definite difference in the pulsations of the posterior tibials was noted. Femoral pulsations were equal. Blood pressure—right arm 168/88, left arm 180/98, right leg 190/100 and left leg 196/106. There was slight tenderness in the mid-epigastrium and the same was noted on deep palpation over the aorta. Marked voluntary spasm in the left upper and the left lower quadrants. There was an old right McBurney incision, well healed without diastasis. Rectal exam revealed a rosette of prolapsed hemorrhoids. Neurological examination was essentially negative.

Laboratory data showed an initial white blood count of 21,550-91/9. Hemoglobin 13.5 grams. Routine stool examination negative. Sputum examination negative for tubercule bacilli or pneumococci. N.P.N. was fifty-five milligrams per 100 cc. Serology negative. Blood sedimentation rate — 67 mm. in one hour-200 mm. tube. Urine showed a fixed specific gravity with a trace of albumen recorded consistantly and a few granular casts.

An x-ray of the abdomen in the sitting position did not show air under the diaphragm. No opaque calculi were seen, and the kidney, ureter, and bladder areas were free of obvious abnormality. The heart was enlarged in its transcardiac dimensions, otherwise a seven foot chest plate was essentially normal.

The electrocardiographic tracing three, five and six days following admission, were abnormal and thought to be the result of a myocardial infarct. Two subsequent tracings seemed to confirm this impression with the Q.R.S. complex slurred in leads I, II and III. RT_1 was above the base line, followed by a positive T_1, RT_2 above the base line and followed by a negative T_2.

After the failure to make a diagnosis of an acute abdominal surgical condition, this patient was accepted on the general medical service as a case of dissecting aortic aneurysm. Pain and discomfort were relieved by opiates. His blood pressure fell to 160/98. The pulse was never recorded over 100. Adbomen was never distended. Urinary output was normal. He apparently seemed much brighter and better until the evening of the ninth hospital day, when he sat up in bed, called for an orderly and was found extremely cyanotic and gasping for breadth. He fell back in bed and died almost immediately, eleven days from the onset of symptoms.

The clinical diagnosis was dissecting aortic aneurysm, and generalized arteriosclerosis with hypertension.

The post-mortem examination showed a dissecting aneurysm in the medial portion of the aorta, extending from the ascending aorta around the arch and down the descending aorta through the abdominal portion into the common iliac arteries. There were two ruptures of the intima into the media. The inferior one of these was presumably, from the clinical point of view, the first. A rupture was seen on the anterior aspect of the descending aorta, immediately below the junction of the left subclavian artery. The superior laceration was seen in the ascending aorta at the beginning of the arch. There was a connection between the medial cavity below the inferior laceration and the right pleural cavity. The latter was filled with a large amount of blood and clot, representing at least one-half the entire body content of blood.

The anatomical diagnosis was, dissecting aneurysm of the thoracic and abdominal aorta, and a right hemothorax.

Comment: Although the admission diagnosis and impression were incorrect, when the history and physical examinations were complete, the mode of onset, persistent pain, persistent high blood pressure with inequality of pressure and pulses, slight icterus, equivocal electrocardiographic tracings (atypical coronary "T" waves) gave the clue to the correct diagnosis. Terminal rupture into the right thorax is quite unusual. His demise was typical.

Case No. 2 — F. H. — No. 359-840 a seventy-two year old day laborer, native born American, entered the Hartford Hospital, September 29, 1938, in a state of collapse.

History as obtained was considered inaccurate.

While burning brush at his work he suddenly felt "everything go black before his eyes," experienced a choking, suffocating sensation in his throat, and fell to the ground. He was unconscious for one to two minutes. When he revived, he complained of no pain, but felt weak, and perspired profusely. He was conscious on arrival in the Accident Room forty-five minutes after the onset of symptoms, but on examination neither pulse nor blood pressure were obtained. Extremities were cyanotic. cold, and drenched in a profuse perspiration. Respirations were of the Cheyne-Stokes type. Heart was enlarged in all directions and the left border of dullness was percussed in the anterior axillary line. Following the institution of shock routine, blood pressure was recorded as 60/50 and pulse as 90 per minute.

When condition warranted, further physical examination revealed an elderly hirsute male, conscious and over-alert with Cheyne-Stokes respirations. He was restless, apprehensive, but we were unable to elicit any symptoms or sign of pain. The pupils were equal and reacted to light and accommodation. The tongue deviated to the left. The retinal arteries showed marked A-V beading and increased arterial reflex. The chest and lung fields were clear anteriorly and moist rales at both bases were noted. The heart rate was rapid and regular and the apical impulse was not seen. Apex percussed in the anterior axillary line. There was a systolic thrill in the second right interspace, palpable in the neck on the same side. The sounds were distant with a gallop rhythm. A long, rough, rumbling systolic murmur transmitted into the right neck was heard. Blood pressure noted equally and with normal variation in the upper and lower extremities, but was fluctuant at 110/80. There was a Babinski on the right.

The provisional clinical diagnosis was acute coronary occlusion with myocardial infarction. Arteriosclerotic heart disease with aortic stenosis and cardiac hypertrophy.

Laboratory examinations were as follows: urine specific gravity 1.024, albumen three plus, white blood cells one plus, and hyaline and granular casts one plus. White blood count 18,100 with 84% polys, 5% lymphs, 11% monos., with a normal smear otherwise. N.P.N. on admission was 46 mg./100 cc., CO_2 combining power 48 vol. % Exclusion and diagnostic Kline tests were negative. Hinton was negative. Electrocardiographic tracing showed a normal rhythm, PR interval 0.17 sec. T_1 and T_3 diphasic. The recording was interpreted as showing myocardial damage and serial tracings were requested.

Hospital course — Despite efforts to treat the patient's obvious shock accompanied by unstable blood pressure and paradoxical pulse, with intra-nasal oxygen and 10% glucose in small amounts intravenously, his periods of apnea became longer, his pulse barely perceptible and his blood pressure could not be obtained. He died of cardiac failure approximately forty hours after admission and forty-one hours after the onset of symptoms

Post-mortem examination showed a heart which weighed 560 grams. The pericardial cavity contained 400 cc of pure blood. There was moderate hypertrophy of both right and left ventricle. The mitral and the aortic valves were both calcified and the aortic valve was markedly stenosed by the calcareous process. In the ascending aorta, there was a saccular dilitation, amounting to a small saccular aneurysm. In the proximal portion of the arch of the aorta, there was a rupture of the intima into the media and there was dissection of the media extending around the arch of the aorta up into the sheaths of the carotid artery on the right, thence into the superior mediastinum. Immediately posterior to the pulmonary artery, there was a connecting channel from the pericardial cavity into the media of the aorta. This channel presumably represented the site of hemorrhage into the pericardial cavity with resultant cardiac tamponade.

Comment: The diagnosis was not made in this case. The mode of onset did not seem to indicate the exact pathology as we know it may. The significance of the development of a paradoxical pulse was not recognized. The atypical coronary "T" waves should have made us suspicious of dissecting aneurysm. Pathological evidence supported the mode of onset.

Conclusions

1. A partial summary, reference, and discussion of the American literature on dissecting aortic aneurysms is presented.

2. From a detailed examination of post-mortem protocols, seven acute dissesting aortic aneurysms may be added to those already reported.

3. Two of the seven are reported completely, in one of which the correct ante-mortem diagnosis was made.

4. No new clinical feature, other than the recognition of syncope at onset, and the subsequent development of a paradoxical pulse is emphasized.

5. The present study indicates that accurate diagnosis and prognosis should and can be made more frequently.

REFERENCES

1. Herrick, J.B., Clinical Features of Sudden Obstruction of the Coronary Arteries. J.A.M.A. 59:2015 1912.

2. Giertz, K.H. and Crafoord, C., On the Thrombo-embolic Disease and Its Surgical Treatment. Acta Chir. Scand., 64:121 1929.

3. McGeachy, T.E., and Paullin, J.C., Dissecting Aneurysm of the Aorta. J.A.M.A. 108:1690 1937.

4. Glendy, E. Castleman, B. and White, P.D., Dissecting Aneurysm of the Aorta. Am. Heart J. 13:129 1937.

AORTIC ANEURYSMS

Table 1

No.	Date	PM No	Age	Sex	Type	Primary Dx	Secondary Dx	Tertiary D
1.	1926	51	62	M	Saccular Ascending thoracic	Acute aortic valvular endocarditis Strep. Vir.	Saccular aneurysm (3 cm. diam)	Adenoma Prostate
2.	1926	84	80	M	Fusiform abdom. with early dissect. Saccular Descending thoracic	Rupture abdominal fusiform (10 cm. length)	Double aneurysm and incidental finding	
3.	1929	545	52	M	Two saccular-one arch and one descending.	Arteriosclerosis with coronary acclusion	Double aneurysm incidental finding (1 cm. and 2½ cm. diam.)	Mural thromb. Pul. Infarct
4.	1929	546	76	F	Fusiform Thoracic Saccular Abdom.	Post-Op Cholecystec.Broncho-Pneu	Double aneurysm Incidental finding	
5.	1931	839	70	M	Fusiform Abdom.	Carcinoma of Larynx	Incidental finding (14 x 9 cm.)	Adenoma Prostate
6.	1931	893	60	F	Fusiform ascending arch thoracic	Post-Op. Cholecystec. Pul. Embolus	Aneurysm incidental finding (7 x 4 cm.)	Wound Infection
7.	1931	897	71	M	Fusiform ascending arch thoracic	Arteriosclerotic heart disease, Aortic stenosis Chronic nephritis	Aneurysm Cardiac failure	
8.	1932	916	59	M	Dissecting Thoracic	Dissecting thoracic with mediastinal extravasation	Cerebral infarcts	Lobular Pneu.
9.	1932	921	60	M	Sacculated thoracic transverse arch	Rupture of luetic aortic aneurysm	Atelectasis and infarction of the lt. lung.	C.P.C. Liver
10.	1932	928	73	M	Fusiform and saccular thoracic arch	Calcific aortic-stenosis Left ventricular dilitation	Cardiac hypertrophy Aneurysm incidental finding	
11.	1933	1126	53	M	Fusiform arch thoracic	Reticulum cell sarcoma	Syphylitic aortitis	Aneurysm incidental finding
12.	1933	1160	37	M	Dissecting entire thoracic and abd. aorta.	Secondary ischemic intestinal infarcts result of aneurysm	Cardiac hypertrophy Obestity	Renal calculi
13.	1933	1175	78	M	Fusiform of the abdom. aorta	Coronary Infarction Arteriosclerosis	Aneurysm an incidental finding, Renal infarcts	Chronic nephritis
14.	1933	1189	78	M	Dissecting Abdom old dissection	Adenocarcinoma of colon with metastases	Post-op. general peritonitis	Adhesive pericarditis. Aneurysm
15.	1934	1493	76	F	Abdominal fusiform with rupture and slight dissec.	Retroperitoneal rupture of aneurysm	Intestinal obstruction	Iliac aneurysm
16.	1934	1532	56	M	Fusiform annular dissecting local abdominal	Acute gangreno-purulent appendicitis	Peritoneal Abscess Adynamic ileus	Aneurysm

Table 1 — Continued

No.	*Date*	*PM No*	*Age*	*Sex*	*Type*	*Primary Dx*	*Secondary Dx*	*Tertiary D*
17.	1935	1702	75	M	Dissecting descending thoracic and upper abdominal	Ruptured mesenteric vessel due to aneurysm with retroperitoneal hemorrhage		
18.	1935	1828	16	M	Saccular of the first descending	Rupture of aneurysm with exsanguination	Coarctation of the the aorta	
19.	1936	2060	74	M	Saccular Abdom.	Myosarcoma of the urinary bladder	Acute hemorrhagic cystitis	Aneurysm incidental finding
20.	1936	2125	65	M	Slight dissecting ascending arch	Rupture of dissecting aneurysm	Cardiac tamponade	
21.	1937	2233	62	M	Dissecting Abdominal	Rupture of dissecting abdominal aortic aneurysm	Massive retroperitoneal hemorrhage	
22.	1937	2259	80	M	Saccular and fusiform of the ascending arch with sl. dissection	Rupture of dissecting aortic aneurysm with hemopericardium	Cardiac tamponade Marked atherosclerosis	Adenoma of kidney
23.	1937	2359	84	F	Saccular abdom.	Cerebral Thrombosis Bronchopneumonia and Arteriosclerosis	Aneurysm incidental find	
24.	1938	2500	80	M	Saccular Abdom.	Lobar Pneumonia	Perforating duodenal ulcer	Aneurysm incidental
25.	1938	2537	64	M	Saccular Abdom.	Rupture of urinary vesicle diverticulum	Rupture of abdom. aortic aneurysm with retroperitoneal hemorhage.	
26.	1938	2696	72	M	Dissecting thoracic (ascending, arch, and descending)	Rupture of dissecting aneurysm with hemopericardium.	Calcified mitral and aortic valvular disease	
27.	1938	2698	50	M	Dissecting thoracic and abdom. Extensive	Rupture of dissecting aortic aneurysm	Rt. Hemothorax	
28.	1939	2871	52	M	Saccular Abdom.	Rupture of aneurysm into duodenum with massive intestinal hemorrhage		

REFERENCES — Continued

5. Nicholls, Observations Concerning the Body of His Late Majesty. Philosophical Transactions London 52:265 1762.

6. Morgagni, J.B., The Seats and Causes of Diseases Investigated by Anatomy. In five books containing a great variety of dissections with remarks. Translated from the Latin by Benjamin Alexander, London, A. Milla and T. Cadell 1:802 1769.

7. Maunoir, J.P., Memories physiologiques et practiques sur l' aneurisme et la ligature des arteres. Geneva 1802.

8. Laennec, R.T.H., A Treatise on Mediate Auscultation. P. 761 1846.

9. Pennock, C.W., Case of Anomolous Aneurysm of the Aorta Resulting in Effusion of Blood between the Laminae Composing the Middle Coat of that Vessel. Am. J. of Med. Sci. 23:2 1838.

10. Swaine, Dissecting Aneurysm of the Aorta. Trans. Path. Soc. London 7:106-111 1855-1856.

11. Peacock, Report on Cases of Dissecting Aneurysm. Tran. Path. Soc. London 14:87-125 1863.

TABLE II.

Clinical Observations in acute Dissecting Aortic Aneurysms

Autopsy No.	*Pres. Symp.*	*Heart*	*B. P.*	*Neurological*	*Circulatory*	*Prov. Diag.*	*Type of Death*
916	Coma	Enl. in all diam.	Prev. History high B.P. 154/64	0	Cold - blue left arm and hand	Coronary occlusion	Respiratory in 4 hours
1160	Severe back pain	P-88 sl. enl.	Prev. Hx High B.P. 175/105	Flaccid paralysis legs Incon. feces	Cold, cyanotic skin	Hematomylia with cord transection	Circulatory shock 12 hours
170	Severe back pain subsided	Poor sounds sl. enl.	182/120	Paralysis lt. leg-retd. to normal	0	Acute intrathoracic infection. Essential hypertension	4 weeks gradual cardiac
2125	Coma	Gen. enl.	Prev. Hx. high B. P. 90/60	Babinski, lt. wk. lt. arm and leg Abs. abd., A.J. K.J.	Rt. radial absent	Coronary occlusion	Sudden cardiac tamponade 3rd day
2233	R.l.q. pain to back-syncope	Gen card. enl.	B. P. high Hx 220/110- 70/60 140/80	0	Cold, clammy mottled cyanosis	Ruptured appendix Hyper. H.D.	Died 4 days P.O. Sudden cardiac
2696	Syncope	Gallop rhythm signs aortic stenosis enlarged	Not obtained on admission 70/50 110/80	Babinski on right transient	Persistent shock level B.P. Loud systolic in back	Corinary occlusion A.S.H.D. with A.S.	Died 48 hours cardiac tamponade
2698	Severe knife-like pain, rt. back Weakness-dizziness	Gen. enl.	Prev. Hx high B. P. 190/106	Numbness in lt. leg	Difference in pulses rt., lt., and B. P.	Acute back strain	Sudden cardiac and respiratory 9 days

REFERENCES — Concluded

12. Tyson, M.D., Dissecting Aneurysms. Am. J. of Path. 7:581 1931.

13. Shennan, T., Dissecting Aneurysms, Med. Research Council, Special Report Series, No. 193, London 1934. His Majesty's Stationary Office.

14. Weiss, S., The Clinical Course of Spontaneous Dissecting Aneurysm of the Aorta. Med. Clin. of North America. 18:1117 1935.

15. White, P.D., Badger, T.L. and Castleman, B. Dissecting Aortic Aneurysm Wrongly Diagnosed Coronary Thrombosis. J.A.M.A. 103:1135 1934.

16. Hamburger, M. Jr., and Ferris, E.B. Jr., Dissecting Aneurysm., The Am. Heart Journal. 16:1 1938.

17. Wood, F.C., Pendergrass, E.P., and Ostrum, H.W., Dissecting Aneurysm of the Aorta with Special Reference to its Roentgenographic Features. Am. J. of Roentgenol. 28:437 1932.

18. Elliott, A.H., and Evans, R.D., Clinical and Electrocardiographic Picture of Coronary Occlusion Produced by Ruptured Aneurysm of the Abdominal Aorta., Am. J. of Med. Sci. 191:196 1936.

19. Weiss, Sonia., Dissecting Aortic Aneurysm (Two cases with Unusual Features) N.E.J. of Med. 218: 512 March 24. 1938.

20. Roesler, Hugo, Gifford, U.G., and Betts, W.; Dissecting Aneurysm of the Aorta Correctly Diagnosed with Description of a Sign Heretofore not Mentioned. Am. Heart J. 13:426 1937.

21. Middleton, W.S., and Porter, R.R., The Diagnosis of Spontaneous Dissecting Aneurysm of the Aorta., Trans. of the Assoc. of Am. Physicians 52: 67-81 1937.

22. Resnick, W.H., Keefer, C.S., Dissecting Aneurysm with Signs of Aortic Insufficiency. Report of a Case in which the Aortic Valves were Normal. J.A.M.A. 85:422 1925.

23. Hamman, L., and Apperly, F.L. A Clinical Pathological Conference. An Instance of Spontaneous Rupture of the Aorta with Aortic Insufficiency. Internat. Clin. 4:251 1933.

N.B. The above references do not signify a complete bibliography, but only those articles quoted.

Early Days of the Fairfield County Medical Association*

WILLIAM M. STAHL, M.D.,
Danbury, Conn.

The Sesquicentennial of the Connecticut State Medical Society will be celebrated at Middletown in 1942. In anticipation of that event the *Journal* will publish a series of historical papers on different phases of medical history in the eight counties of Connecticut. The following from the pen of Doctor Stahl is the second of this series. (*The Editor.*)

As one analyzes the history of medicine in Fairfield County, and sees the accomplishments of the older men in our profession today, and the men who preceded them, it is but to have the greatest admiration for them.

The existing records of the Fairfield County Medical Association begin with the year 1825. No mention is made in them of any previous date, and in 1826 it was voted to "pay the clerk for advertising medical notices for the last five years, and a record book for such Society, amounting to $6.25."

The New Haven County Medical Association was in existence in 1784 as "The Associated Faculty of New Haven." In Fairfield County, no medical society existed prior to the chartering of the Connecticut Medical Society. To give importance to the movement, and weight to the appeal for the charter of the County Association, several distinguished and influential physicians from other Counties were admitted to membership in the New Haven County Association. Among these were Amos Mead of Greenwich; Joseph Trowbridge of Danbury, and James Clark of Stratford. The desired charter was obtained in 1792, and this year may be regarded as the first of the existence of the Fairfield County Medical Association. The purpose in forming these Associations was "to adopt such measures for the future regulations of our salutary art, as shall effectively support and countenance merit, and discountenance their presumptions; the encouragement of an accurate study in the theory and practice of physics and surgery; to collect and preserve useful papers relative to the practice of medicine." It was their purpose then, as it is ours now, "to keep our great and sacred ars medendi above the plane of an ordinary business which advertises and solicits trade; to protect and help our members, and so far as possible to educate the public and protect them from charlatanism." They recognize the benefits to be derived from association and discussion, the contact of mind with mind — "Everything intended to encourage their coming together."

The first meeting of which we have the record was held at the house of Silas Camp in Bridgeport on the third Monday of April 1825. Meetings at that time were held annually, at different towns in the County, sometimes at the houses of persons who were not members, sometimes in Inns.

One is forced to smile at the absurdly small fees which these men received, and the nicety into which they divided the different departments of their business, yet the table was one of their own making. It must have been in some degree satisfactory — it affords a pithy lesson of the progress of the times. "At the annual meeting holden at the house of Levi Edwards, Esq., of Monroe, April 20th, 1829, it was voted that the following services and medicines shall not be rendered nor furnished for less sums than are designated, that is: — Bleeding, 20 cents; cathartic, 21 cents; emetic, 10 cents visit, 17 cents; travel, per mile, 17 cents; obstetrical cases, $2.50; instrument, $4.00; extracting tooth, 12 cents."

The Association was in part for the protection of its own members. At the meetings in which the by-laws were adopted, the following resolves were passed, which seemed to have been for that purpose. This meeting was held in 1856 at the City Hotel in Bridgeport. Dr.

---

*Address of retiring president delivered at Bridgeport, April 19, 1940.

Blackman moved the following: —

"RESOLVED — 1st: That any physician who under charges his neighbor in his neighbor's vicinity with a view to supplant said neighbor or otherwise to interrupt his business, justly deserved to be disrespected by every member of our Society.

Second Resolve: — That opinions on cases of disease shall, unless otherwise agreed in consultations, be considered as sacred and not to be divulged.

Third Resolve: — That an uniform rate of charging be desired, to which — when established by vote of our Society — every member shall adhere, on penalty of being adjudged by the standing committee as to them shall be deemed just and proper."

But the sons gradually departed from the customs of their fathers as regards the usual proceedings of the meetings — an exchange of good wishes all around — a general discussion of medical topics — the appointment of delegates and committees — and readings of papers voluntarily proffered — the discussion and disposal of questions of discipline — now occupy the hours, while a concluding dinner at the hotel sends each one home better acquainted with his neighbor personally and stronger for another year of service. In the old type of meetings, all business was transacted during a meeting, scientific papers were read, and it seemed like a great deal of ground to cover. Some years ago the business end of the meeting was divorced from the scientific end. Also, scientific meetings were arranged in the way of symposia on various subjects, which have proven tremendously interesting. An organization has been gradually developed to help bring the profession to the service of the public.

I believe that one of the most interesting books I have ever read was the minutes of the proceedings of the meetings of the Danbury Medical Society. These notes go back to 1887. It is interesting to note that our own Dr. D. Chester Brown — who has done so much for this County Association — was its first secretary. In this book can be found papers on the treatment of diphtheria before the advent of antitoxin; the arrival of Koch's lymph from Germany. It speaks of typhilitis, and also of laudible pus. At that time there was no hospital. The minutes of one meeting referred to efforts to obtain two houses for use as a hospital. There were no surgical operations performed.

It is interesting to read of the struggle which these men had to obtain a place in which to do their work, and of the reluctance of people at that time to go to a hospital. It can readily be seen — the tremendous effort these men put into the practice of medicine and the building of a hospital, which, at the present time, seems to be accepted without much thought or sense of appreciation. It is a peculiar trait of human nature that we accept some of these conditions as they are at the present time, without much thought of the effort that has gone into them. Just as the young people of today accept the automobile, radio and television, so do we accept our modern hospitals, with all the improvements in technique, diagnostic instruments and laboratories. I here wish to pay tribute and my own debt of gratitude to the outstanding pioneers who have preceded me.

Hospitals necessarily owe a sense of protection to the public. They are responsible for the quality of service and the type of work which is done in them. It is important that the senior men make an effort to educate younger men to follow in their footsteps for the servicing of the various staffs throughout the hospital. It is important that every effort be made to evaluate the practice of medicine.

There has to be some control of the running of these institutions and the protection of the public from such things as unnecessary operative procedures. It has always been my experience that men who adhere to honest principles, who are capable, and willing to work, usually succeed, and that these men have no fear for the future.

I recently talked to a man who is an outstanding surgeon in this County, who has a son who some day will probably be following in his father's footsteps. The father made the statement to me "that he had come up the hard way — by hard work — that he did not have everything handed to him, and he felt that it had made a much better doctor and a much better man of him, and that he hoped his son would have to do likewise." One does not appreciate the things too easily obtained.

I always feel in looking at institutions such as our large hospitals, that the men who were instrumental in making such hospitals possible must have had a great deal of pleasure and enjoyment in contributing toward the building of them — they are part of himself — and consequently he takes a tremendous interest in them. The younger men who find them already there have missed the joy and pleasure of its building, but always can have a part in running the machine which has been built for them, and in keeping its standards high.

What we need now — more than ever, since the medical profession is being assailed by various groups — is a spirit of cooperation, building up and trying to evaluate our profession to the point where it is above reproach. Every medical man should conduct himself in such a way that he cannot possibly be criticized, and if this is done our adversaries will soon be put in the background and the profession emerge triumphant as a profession and not as a trade.

It always has seemed to me there are a few men in every organization who shoulder the burden of the whole group — every man should take an active interest — THIS IS YOUR ASSOCIATION. The public should be educated as to the accomplishments of the medical profession — what it is trying to accomplish — what it has done in the past and still is willing to do.

Apparently these men in the olden days had their problems. Some of these same problems still remain with us. In addition we have others. It would seem that right now the future of American medicine is being assailed, and it is pathetic — the indifference displayed at the present time by a large portion of the medical profession to our present problems. Unless the medical profession wakes up and takes an active interest, it is felt that they may find themselves in a sorry plight. One would not believe that such a situation could exist, especially after nearly one hundred and fifty years of splendid service rendered by members of this Association alone. You have an opportunity now, through the National Physician's Committee, composed of the country's outstanding medical men, willing to fight your battles. The least you can do is to support it. It is now time that medical men forget whatever petty jealousies or grievances which they might have and combine as one unit in the support of American Medicine.

Certainly there is no group of men who come closer to the public than physicians. I believe it is the duty of every medical man to acquaint his patients and the public with the dangers of possible legislation which would tend to federalize American medicine. The importance of medical men taking a very active interest in their local medical Society cannot be over-emphasized.

Surely, after all these years of service, the medical profession should not find itself in a position where it can be dictated to by a group of Doctors of Philosophy.

——☆☆——

RESOLUTIONS ON "DEAFNESS"

Whereas, accurate definition of terms relating to auditory function is important for medico-legal as well as for society and educational purposes the American Otological Society,

Now Therefore Resolves that the term "deafness" shoud be reserved for loss of useful hearing; lesser degrees of auditory loss should be designated as hearing impairment, hearing defectiveness, hearing deficiency or malaudition,

Be It Resolved Further that the American Otological Society hereby requests that the existing Committee of the Council on Physical Therapy of the American Medical Association proceed forthwith to the formulation of standards for the evaluation of deafness and hearing impairment including tinnitus and vertigo in order that such standards may be set up for the guidance of Commissions, Courts, Insurance Examiners and other medico-legal agencies and that copies of these resolutions be sent to the editors of the Journal of the American Medical Association and to each State Medical Journal, and

Be It Resolved Further that the American Otological Society suggests to the Committee on Medical Education and Hospitals and on Physical Therapy of the American Medical Association and to the Associated Medical Colleges, the improvement of instruction to medical graduate students in the fundamentals of the detection, amelioration and prophylaxis of hearing defects and further suggests that information on these subjects be made available to the committees on Graduate Education of the several State Medical Societies.

Common Sense in Psychiatry*

C. C. BURLINGAME, M.D.,
Hartford, Conn.**

Within the past two generations I presume no branch of medicine has run so high, wide and handsome as psychiatry and the resultant confusion regarding it is great. But if you will bear with me and look back into our parentage, perhaps, you will find some very humble beginnings. I may as well tell you, if you do not already know, that we had our beginnings among soothsayers, metaphysicians, mesmerists, etc. who, uniting with the keepers of the poorhouse and the jail, eventuated in the alienists of yesteryear. You see, we were not nurtured in the general hospitals, the medical school and the centers of higher education; all of these good things came to us later.

But while I confess to a weakness in our early beginnings, I might also call attention to the fact that the aristocrat of the medical sciences — I refer to the surgeon — had an equally humble beginning in the barber shop of ancient times, and the internist can still find some of his distant cousins practicing voodoo rites in darkest Africa — and even in the islands of the Caribbean. I do not mention these skeletons in the family closet in order to embarass my brothers in the other branches, but merely to point out that each had his humble ancestry but has found his way into modern scientific medicine through different media and pathways. It was the very nature of our origin that first attracted our attention toward institutional and custodial care — primarily as a protection to society. Next we studied the psychological side of man without giving adequate attention to physical medicine, and it was the attitude of society toward so-called mental disease that continued an isolation of mental disease from the rest of medicine for a considerable length of time.

Pasteur and other pioneers in the physical sciences related to medicine, on the other hand, directed intensive study to physical man and almost, if not completely, disregarded man's psychological being and his emotional self.

With this advent of physical scientific medicine, man ceased to be an individual and was looked upon as a group of organs — either diseased or healthy. In the early days of scientific medicine the good old family practitioner was still permitted to regard a sick man as having emotions related to a sick body, but this conception largely yielded to the test-tube and the microscope.

And what was happening on the other side of the picture? Kraeplin came along and out of a hodge-podge of loose thinking and looser talking about mental disease he developed a classification of disease and introduced the terms manic depressive psychosis, dementia praecox, etc., etc. Patterning his thinking somewhat after that of his brothers in physical medicine, he emphasized these impressive terms as disease entities, rather than as purely descriptive terms, and I am afraid that his contributions to descriptive psychiatry resulted somewhat in the retarding of our therapeutic thinking. It was, however, a searching in the right direction.

Then along came the school of psychogenic thought, the extremists of which assigned a psychological and emotional cause to almost all the ills that human flesh is heir to and, more particularly, to so-called mental disease. Some went to such extremes that they almost left the mind floating around without a body — indeed, it is not so many months ago that a proponent of this school charged that a world-wide epidemic of influenza was directly chargeable to man's emotional upset over a world war.

But a lot of water has gone over the psychiatric dam since the descriptive psychiatry of Kraeplin, and the subsequent tremendous enthusiasm of the purely psychogenic school of thought. And I might add, there have been many upsetting considerations. In the era when mental disease was largely ascribed to "bad heredity", it was most disturbing to have Nagouchi find the spirochete in the brain of a paretic, thereby making heredity much more respectable in the case of paresis. But we have progressed another step. The psychiatrist of today admits that man has a body; he also admits that that body has a mind; and he even goes so far as to admit that if that body is separated from the mind, there is not very much the psychiatrist can do about it — because the patient is dead.

---

*Given before the Stamford Medical Society October 8, 1940.

**Psychiatrist-in-Chief, Neuro-Psychiatric Institute of the Hartford Retreat.

And now, if you will bear with me, I will cite a few examples of this gradually accepted relationship between the mind and the body. I have just mentioned paresis and its identification as a form of brain syphilis I recall that thirty-three years ago, when I started in psychiatry, we would make a diagnosis of paresis on the psychogenic factors even if the physical factors were lacking — and we were usually right, but the psychological picture was that of exhilaration, euphoria, etc., etc. It was not until the colloidal gold and the laboratory identified paresis as a specific disease entity that we were able to disassociate the psychological symptoms of thirty-three years ago or, more accurately, re-associate the psychological symptoms of paresis. We know now that paresis may have the symptoms of neurasthenia, or of a reactive depression, or of an ordinary manic depressive reaction — in fact, the mental symptoms of paresis may simulate almost any of our so-called descriptive mental diseases.

Again let me mention some of the pellagra psychoses which sometimes simulate toxic psychoses, at other times the confusional states or manic states, and various other psychogenically identified mental diseases. I might touch upon the use of the nicotinic acid in these conditions with the resultant disappearance of the various symptom complexes; also upon the use of nicotinic acid in the sub-clinical pallagras, where only mental symptoms are apparent, and the disappearance of every mental symptom. All of this leads one to the conviction that with our present day means of diagnosis we are usually not able to identify most fundamental dietary deficiencies, to say nothing of a multitude of other dietary dystrophies.

Again, I might mention some of the endocrine work being done along the line of estrin deficiencies, more particularly at the so-called involutional period, and there is some evidence that just as paresis has taken a slice off some of the psychogenic diagnoses, vitamin replacements are doing a similar thing. In addition, there is much evidence that the same cutting into so-called mental diagnoses is happening with the estrin deficiencies.

But I will not dwell any longer upon the evidence of change coming about in psychiatry along the line of appreciating the inter-relationship of the psyche with the soma. We have gone some way along this line but it is a beginning. I am firmly of the conviction that time will reveal to us that there is no such thing as a purely mental disease.

The studies of Bassinette on the effect of light on the procreative functions of starlings seem to justify a line of reasoning which foresees that every emotion and every environmental factor must find itself registered through a chemical or electrical change in physical, chemical somatic man.

And now let us turn to the other side of the picture. What has the surgeon, what has the internist, what has the pediatrician learned about psychological medicine? A great deal, I would say, but just as the psychiatrist has an enormous amount left to learn about the psyche and the soma, so the practitioner of physical medicine has a tremendous amount yet to learn about the connection between the soma and the psyche.

No thoughtful person will deny the fact that an individual's personality is changed by a physical disease, but how many of you have given thought to the fact that a person's emotions may produce an actual physical change in the human body? This has been demonstrated histologically and chemically, as, for example, in the incidence of gastric ulcer which has been experimentally produced in experimental laboratories by the use of purely mental factors. How many of you have given thought to the gradations all the way from this profound physical change to the as yet unidentifiable but crippling disorder of which patients still complain after you gentlemen have assured them there is nothing wrong with them?

Hall, in Banting's laboratory, has demonstrated that anginal attacks can be produced on a purely mental basis and, through repeated mental strains, fatal attacks may be induced. It is interesting to note that in Banting's laboratory these same animals, with the emotional fibres of the vagus severed, are incapable of subsequent anginal attacks and cannot be destroyed that way.

But now, what of that army of patients we receive from men of somatic medicine who come to us with the statement that they have received assurance there is nothing wrong with them, or "it is just their imagination"? Let me assure you that 90% of all these still sick patients who come to us after having been told there is nothing wrong with them, have a very keen resentment against their doctors and, only too often against the medical profession in general. After having a complete laboratory work-up and an excellent physical examination and being told there is nothing wrong with them, they have found their way to the natureopath, the chiropractor and Lord knows who all. There is one thing that almost all of these irregular practitioners have in common, — they understand human nature and they will take the time to manipulate human nature. They are never too busy to go into the emotional life of an individual — that is one thing they never neglect. Sometimes their motives may be open to question, but there is no secret of that person's inner life that they are not able to extract and not skillful in evaluating. As a by-product, the money may come out too. The charlatan who has gotten at the emotional problems and worked them out crudely with his patient may use an ultraviolet ray as the vehicle to a cure and to the patient's pocketbook.

I think of one instance of a chap who, after having made the rounds of the best in somatic medicine, landed in the hands of one of these gentlemen who used ultraviolet ray along with a sales talk in which he assured his patient that there were only three lamps of the kind in the United States of America, — one at the Mayo Clinic, one at Johns Hopkins, and he was the modest possessor of the third. He gave a first-class treatment with a resultant second-degree burn, but this so-called doctor had already taken the emotional and psychological measure of his patient, and glibly passed it off by saying "fine, wonderful result; now we are really getting some of the badness drawn out through the skin." The disturbing part of the story is that the patient's disability vanished purely as a result of this irregular practitioner having gotten at the emotional factors in the individual's life. I hardly need pause to say that I am not recommending this procedure to you gentlemen. I merely cite it as an incident to show what happens over and over again to the patients who are being pushed out of doctors' offices with the assurance there is nothing wrong with them and with the advice to take a trip, or a vacation or a rest, or to forget it. When you cannot put your finger on a somatic condition, and when you cannot see clearly a line of physical medicine along which to proceed, it is incumbent upon you to take the time to go into that patient's emotional life and, in the absence of finding a bug, find out what else it is that is biting him — because there is always something. Just remember that many wives — and many husbands, too — are more than pains-in-the-neck; they may be, literally, pains-in-the-stomach.

The ancients knew there was a connection between our mental life and our physical selves; such expressions as "your heart in your mouth", "goose pimples", "he has guts" or "he has no guts", bear this out, and numerous other vulgar and less vulgar expressions recognize the fact that they appreciated that the mind has an effect upon the body.

You will find that nine times out of ten, if you give them time, a considerable number of these patients will unfold their mental problems to you if you will merely be an intelligent listener; and you will assist them to eliminate their distressing symptoms if along with some somatic treatment as a vehicle, you will help them unravel their emotional difficulties.

I do not recommend that you undertake any long-winded psychoanalytic procedure covering a period of years, and at an outlay of many thousands of dollars. It is only a chosen few patients who can afford such a luxury. You will have to take the hard-headed, practical view of helping the psychoneurotic, hypochondriac, or whatever you may call him, to adjust to life, and he must get such help unless he is to withdraw from life in some degree. Your failure to give him this help, or to see that someone else does, will in all probability mean a gradual withdrawal from life at least to some extent. It may be merely a chronic bad headache which incapacitates a person, or it may be a heart symptom that makes a person only a semi-invalid, or it may be a complete and chronic invalidism, or it may be a flight from reality in alcohol, or drugs, or it may be a full-blown psychosis. The mechanism in each case is essentially the same; it is merely a matter of the degree of their flight as a result of their inability to emotionally adjust to life as they must in order to meet their problems.

Any psychiatrist would find it most interesting to talk to you for the next hour or two about the details of technique and procedure; this is a never-ending and always entrancing study. Practice does not make perfect, but practice adds to one's effectiveness and, I dare say, it will add interest to the practice of your profession to say nothing of marked increase in your effectiveness. I do not expect you to undertake the heavier and deeper psychiatric work but you can get a point of view and increasingly help prevent the staggering tolls of mental illness.

Let me conclude by saying that I look forward to the time when we will stop talking about "mental" disease as distinguished from "physical" disease. I believe there is no such thing as mental disease, as you may have been talking of it. and I am sure there is no such thing as purely physical disease. There is just disease, and it is merely a matter of whether the presenting symptoms are predominantly somatic or predominantly psychogenic.

God speed the day when the psychiatrist will be a profound student of the human body as well as the mind, and God speed the day when no man will be practicing somatic medicine without a fundamental knowledge of the psychological accompaniments and possibilities. Medicine never will be at its best until it is practiced as an art as well as a science. It is only when the physician considers both the mind and the body of man that medicine becomes an art as well as a science.

* * *

POLITICS MARCHES ON

Under the Soldiers Relief Commission of the state, patients have been admitted to the University Hospital for entirely free service, who have been in financial position to pay for night and day special nurses and whose relatives were able to make a choice of automobiles in order to determine which car the chauffeur is ordered to drive to the hospital.

By executive order an individual has been admitted to the University Hospital for observation and treatment, although he may be in position to travel to the east or north for confirmation of the diagnosis given him here gratis, under the name of indigent sick. By virtue of membership in certain select governmental units, of this state, one may receive medical care entirely free — all because Oklahoma has provided so well for the indigent sick.

Under the Crippled Children's Act, adolescent girls suffering acute pelvic pathology are admitted to the Children's Hospital. Under the Crippled Children's Act a distinction is made between congenital defects. Should the unfortunate child have a cleft palate, the surgeon is paid for the care of the patient; should he have a congenital hernia, the surgeon is not paid for the care of the patient.

It has recently been reported to the writer that a patient on clinical service at the University Hospital not only demanded but received special nursing care for which he was able to pay. In the name of heaven, gentlemen, are these the Crippled Children and indigent poor that we are providing for!

Jour. Okla. State Med. Assoc. Oct. 1940

BLOOD PRESSURE? PRESTO!

You are always asking, "What's new?" The Taylor Instrument Co. answer with their introduction of a manometer cuff based on an entirely new time saving principle. Fits instantly all sizes of arms without twisting or slipping. For sale by The Professional Equipment Company. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

(SEE PAGE 2)

Child Guidance*

GEORGE K. PRATT, M.D.,**
New Haven, Conn.

Child guidance as one form of psychiatric service is akin to preventive medicine. Whereas conventional adult psychiatry strives to undo or to stem mental damage that already has occurred, child guidance endeavors to nip it in the bud before it gets a head start. This is logical in view of present knowledge concerning the causation of many psychiatric conditions; a knowledge which sees a direct connection between numerous behavior and personality disorders in the formative years of childhood and the tendency for some of these to flower into crippling mental disorders in adult life. Sufficient experience has now accumulated to demonstrate that if any attack is to be successful against our rising tide of institutional mental disease, then preventive efforts during childhood must become the spearhead of that thrust.

The general practitioner may ask the nature of these behavior and personality difficulties in childhood which, when carried over into adult years so often form the fabric from which serious psychiatric conditions are made. The answer is simple since there is no one — whether he realize it or not — who comes in contact with these problems more closely and more often than this same general practitioner. They include conditions such as the habit of temper tantrums, of 'babyish' speech and conduct persisting into age periods when infantile attitudes ordinarily are left behind, of fussy, finnicky food habits, of tics and choreiform movements untraceable to any organic cause. They also include problems of jealousy between siblings, of excessive attachment to one parent or the other, and of longstanding shy, withdrawing and unsociable contacts with others. They include a host of anxieties on the part of the child with his physiological functionings which often prove the precursors of hypochondriacal states years later, and lastly, they include a wide variety of behavior labelled as delinquency, ranging from stealing to setting fires or unacceptable sex conduct.

So frequent are these problems, so universally do physicians and laymen alike accept them merely as household exasperations to be put up with until the child 'outgrows' them, that their real significance all too often is overlooked. The plain facts are that it is rare for a child to 'outgrow' one of these problems once its habit is well established. What happens instead is that he tends to carry over the particular behavior or personality difficulty into successive age periods until adult years are reached when it is likely to become crystallized and incorporated as a permanent part of his adult makeup. True, the outer form or symptom of the difficulty often is transformed or disguised as the child grows older so that the end symptom may appear to have little resemblence to the original, but the purpose behind the behavior or personality trait remains the same. Thus, (taking one extremely common example) the habit of enuresis may disappear in a given child under well meaning but illogical disciplinary measures, only to have him begin to steal or to set fires. In not a few instances these apparently unrelated symptoms stem from the same original source and one is found to be merely the symptomatic equivalent of the other. In such cases the child seems to have 'outgrown' his enuresis, but in reality he has merely exchanged one mode of expression of his inner conflicts for another.

Physicians engaged in child guidance activities thus find it necessary to concern themselves more with seeking the underlying meaning of the child's symptoms than with focusing attention on the symptom itself. Invariably they ask themselves the question, 'What does this particular mode of behavior mean, and why has it become necessary for the child to develop it?' — Not until a satisfactory answer is found can an effective program of treatment be formulated.

---

*Read at 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

**Assistant Clinical Professor of Psychiatry and Mental Hygiene, School of Medicine, Yale University. Medical Director, Child Guidance Clinics, Bridgeport and Stamford.

And now, what of treatment? Discussion of this aspect of this five minute paper brings us back to causation. While some child guidance problems undeniably are caused by purely organic or physiologic difficulties, these seem to be comparatively few. Certain others appear to represent the response of a possibly inadequate biologic endowment to difficult life experiences. But in a far greater number of cases the child's behavior or personality turns out to be a reaction to attitudes he habitually encounters in his home and school. Thus, the attitudes, the personality and the behavior he is exposed to day in and day out from mother, father or teacher is the first — and frequently the last — source in which to seek the reasons for the maladjustment of all but a handful of so called 'problem' children, and well verified indeed is the mental hygience slogan that 'nervous, unstable parents make nervous, unstable children.'

In an astonishing number of instances, therefore, treatment of a behavior or personality disorder in a child becomes necessarily the treatment of the parental attitudes that caused it. But this unhappily, is not as simple as it would seem. Few, if any mothers and fathers wish deliberately or consciously to be 'bad' parents. But many of them are the products themselves of unwise, unstable parents of an earlier generation and now in their own parenthood are expressing toward their children the unhealthy traits and attitudes they failed to 'outgrow' in their developmental years. Most of them are honestly unaware that they are fettered by these attitudes and with equal honesty do not recognize what they are doing to their children through them. Consequently, after correcting any physical causations, the physician's first efforts at treating the child through the parent must consist of bringing to the latter a realization of the connection between the mother's or father's behavior and that of the child. The delicacy and frequent frustration of this effort is too well known to every physician to call for comment. Merely to 'tell' the parent what he is doing to the child and to order him to 'stop' seldom avails. Indeed, if the parent already has a glimmer of his role in the production of the problem (such as a mother who, in her private thoughts is rejecting her child) and who perchance, already is feeling a twinge of guilt, he will feel too threatned by its blunt revealation from the physician to cooperate in changing his attitude.

Fortunately for this state of affairs new psychiatric techniques are being worked out which often bring success. The scope of this paper is too meager to embark on a detailed description of such methods, but a clue can be found in the suggestion for the doctor to take time to strengthen and cement his relationship to the parent until the latter is ready to receive — and infinitely more important, to accept and digest — therapeutic suggestions for changes in attitude.

Objection may be raised by the busy general practitioner to the time-consuming nature of this procedure. If so, it is too bad but there are as yet no short cuts. On the other hand, child guidance problems whether recognized as such or not, permeate such a large area of every doctor's case load (especially that of the pediatrician) that time spent in their patient manipulation should bring rich rewards.

One word of caution. Successful practice in this child guidance field of preventive medicine cannot be achieved by every doctor. In the first place, certain minimum professional preparation is required in the form of familiarity with newer psychiatric concepts and methods, although this does not imply that the physician who would enter this field necessarily must be psychiatrist. But what is required most of all is a special temperament on the part of the doctor; a temperament that genuinely likes people, that is understandingly imaginative, that is tolerant of human frailities, that is afflicted with no obsession to 'make' people do what he thinks is right, that is noncondeming in his judgments, and perhaps most of all, that can take frustration from his patients without feeling the need to retaliate by punishing them.

With these attributes and professional preparation any competent physician can play a vital role in stemming the flood of mental disease that threatens to engulf us all if child guidance is ignored.

The Diseased Cervix As a Cause of Symptoms in Women*

HARLAN B. PERRINS, M.D.,
New Haven, Conn.

Owing to the short space allowed for this discussion, I shall limit myself to the non-specific infections of the cervix arising from trauma. The trauma referred to is that of childbirth, miscarriage, and occasionally instrumentation.

The endocervix from external to internal os has a great many racemose glands with small ducts emptying mucous into the cervical canal. These glands were first described by Naboth and are known as Nabothian glands.

It is quite easy to understand that in the severe dilatation to which the cervix is subjected in labor there may be much damage to the ducts of these glands, even in the absence of gross tearing of the cervix. This damage in turn interferes with adequate drainage of the Nabothian glands, providing an excellent site for invasion by the vaginal flora.

The organisms found in this type of chronic endocervicitis are commonly staphylococcus and certain strains of streptococcus. This infection of the cervix is evidenced upon inspection by areas of so-called erosion, and by hypertrophy of the organ. Often when the glands are obstructed, shiny opalescent cysts ranging usually from pin-head size to that of a pea will appear on the lips and external surface of the cervix. Upon opening these Nabothian cysts, a thick muco-purulent fluid will escape.

Endocervicitis characterized by erosion only usually shows little evidence of absorption, but usually gives rise to a disagreeable discharge. However, when these glands are partially or completely obstructed and infected, other symptoms and signs quite typical of absorption arise.

The first evidence of deeper invasion is usually a thickening or oedema of the parametrium and uterosacral ligaments. This is easily identified by the feeling of thickening accompanied by marked tenderness on either side of the cervix and by the easily palpable thickening of the utero-sacral ligaments. By lifting the cervix forward, tension can be put on the utero-sacral ligaments, and the pain elicited is a definite diagnostic point in involvement of the utero-sacrals.

Associated with the involvement of the utero-sacral ligaments there is evidence of absorption by way of the posterior pelvis. Severe backache across the sacroiliac region associated with tenderness of the sacro-iliac synchondroses and evidence of sciatic nerve irritation are the usual symptoms. This involvement and its relationship to the endocervix can be easily demonstrated by treating the cervix with a cautery, whereupon there will be, temporarily, a marked increase in absorption and in the symptoms described.

Not infrequently in long standing cases of endocervical infection, there is a definite invasion of the Fallopian tubes sometimes associated with a metritis. The tubes become quite tender and are definitely palpable and cordy. Upon rolling one of these tubes between the fingers in bimanual examination, much the same feeling is noted as one feels upon rolling the vas deferens between the fingers.

Metritis is evidenced by noting a slight enlargement and softening of the uterus with tenderness of that organ. A later symptom quite frequently met with is menorrhagia which ususally appears after years of absorption and is often erroneously diagnosed as fibrosis. However, in these cases the uterus is softened, not hardened, and the endometrium is thickened.

In addition to these relatively local symptoms, certain general systemic symptoms are occasionally met with. A general feeling of lassitude, weakness, and general ill-being may result from these infections. Mild secondary anemias not infrequently result. That these symptoms are directly the result of chronic absorption in cervical infection can be quite frequently demonstrated by their prompt disappearance following the removal of the focus of infection.

---

*Presented at 15th Clinical Congress, Connecticut State Medical Society, New Haven, September 19-21, 1939.

I have been frequently asked by internists to rule out these cervical infections in cases of rheumatism and joint involvements which appear to be due to some focus of infection. While, of course, chronic cervical infections should always be cleaned up in these cases, it has been my experience that only very rarely can any effect be demonstrated on rheumatic conditions by the treatment and eradication of cervical infections except in localized so-called rheumatic involvement of the sacro-iliac joint. Where this joint alone is involved and clears up under removal of a cervical focus, I question whether a real diagnosis of rheumatism can be made.

I presume the reason focal infection of the cervix has so little relationship to rheumatism is that the common infecting organism is not one with a predilection for joints, etc.

Of course the treatment of these infections is destruction or removal of the infected glands, either by cautery, high frequency excision, or surgical removal of the endocervix.

Proper carrying out of this treatment will result in a complete subsidence of the parametritis and utero-sacral involvement, and in relief of such systemic symptoms as are caused by this infection.

Usually uterine and tubal involvement will subside, but occasionally the damage is apparently sufficient for these organs to continue to cause symptoms which ultimately may lead to surgery.

The backache and sacro-iliac involvement usually subside entirely unless there has been bony change in the sacro-iliac joint, which is quite a rare complication.

PURE LUTEINIZING HORMONE ISOLATED FROM ANTERIOR PITUITARY GLAND

The isolation in pure form of the luteinizing (interstitial cell-stimulating) hormone of the anterior lobe of the pituitary gland of swine was announced in the August 23rd issue of *Science* by Drs. Shedlovsky and Rothen of the Rockefeller Institute for Medical Research, New York, and by Drs. Greep, Van Dyke and Chow of the Squibb Institute for Medical Research, New Brunswick, N.J. The achievement is specially noteworthy because the chemical nature of the endocrine principles of the anterior pituitary gland renders them difficult to isolate and analyze since they are proteins or complex polypeptides which are extraordinarily vulnerable to most types of ordinary chemical manipulation.

The significance of this announcement to workers in endocrinology is that it contributes to the elimination of much of the pre-existing confusion with regard to the possible number an effects of the gonadotropic hormones which have been postulated by earlier investigators. In an earlier paper the Squibb Institute workers announced the separation in *nearly pure form* of not only a luteinizing (intestinal cell-stimulating) hormone but also a follicle stimulating (gametogenic) hormone from the anterior pituitary gland. It may be assumed that by using the newest tools for physical chemical investigation which were so helpful in the isolation in pure form of one of the anterior pituitary gonadotropic hormones that the other will likewise be obtained as a pure protein.

Thus far it has not been possible to isolate large enough quantities of these pure hormones for clinical studies. This is obviously the next step as soon as satisfactory yields can be obtained. At any rate it seems to have been clearly demonstrated that two gonadotropic hormones can be isolated from the anterior pituitary gland. They are separate chemical entities and act on different structures within the primary sex gland (ovary or testis).

◆

Pregnancy Complicated by Cancer of the Cervix

Case Report*

ARTHUR H. MORSE, M.D.,
New Haven, Conn.

The hospitals of Connecticut have been invited to furnish one case report each from their clinico-pathological or tumor clinics for publication in the *Journal.* The following from the New Haven Hospital is the first in this series. (*The Editor.*)

The patient, a white Para II, Gravida III, 32 years of age, entered the hospital Dec. 7, 1937. Her last menstrual period began Oct. 23, 1937; the November period was missed. Seven months before admission there was an attack of uterine bleeding lasting one day, and this was followed by a normal menstrual period. Because of the bleeding associated with the present pregnancy the patient thought that she was threatened with an abortion. She, therefore, visited her physician who found cancer of the cervix and who immediately referred her to the hospital.

Excepting the pelvic structures general physical examination was negative. Wassermann and Kahn were negative. R.B.C. 3,970,000; Hgb. 78%; W.B.C. 10,150. Temperature 98^6 — pulse 90. Pelvic examination showed an irregular and firm cervix which was freely movable, and which bled slightly upon digital examination. No extension of the lesion beyond the cervix could be determined. The retroflexed body of the uterus, palpated with some difficulty, was softened and enlarged to the size of a two months pregnancy. A specimen excised for biopsy showed squamous cell carcinoma of the cervix, Grade II. The Aschheim-Zondek test was positive.

In accord with our plan followed in patients with pelvic malignancy, the patient was seen in consultation with Dr. Hugh Wilson, Roentgenologist-in-Chief of the New Haven Hospital. It was felt that the carcinoma should be treated as if pregnancy were nonexistent. On the other hand it was believed unwise to assume the risk of infection, which would be incurred by invading the uterine cavity from below or by an abdominal hysterotomy, and it was decided to rely upon the x-ray for the termination of the pregnancy. Accordingly, the usual course of treatment for cancer of the cervix was begun and over a period of thirty-one days (12/14/37-1/13/38) x-ray therapy was administered in a dosage of 1550 r (measured in air) delivered to each of six fields.

Upon Jan. 9, 1938, the patient was readmitted to the ward complaining of abdominal cramps and vaginal bleeding. The following day placental tissue protruding from the external os was removed with an ovum forceps. The uterus contracted satisfactorily and within twenty-four hours bleeding ceased.

X-ray therapy was completed upon Jan. 13th and the patient left the hospital upon Jan. 17th. A discharge examination at this time revealed a notable shrinking of the cervix as a result of x-ray administration. The body of the uterus was well involuted and firm.

Upon Feb. 23, 1938, the patient re-entered the hospital for the administration of radium. The cervix was freely movable and now still more shrunken. There was no evidence of lateral extension of the growth. Upon Feb. 24th 40 mgm. of radium screened by 0.5 mm. of platinum were inserted into the uterine cavity and at the same time a trilobed colpostat containing 40 mgm. of radium screened by the equivalent of 1.0 mm. of platinum was applied to the fornices and cervix. Thus 3,000 mgm. hours of radium were administered to the cervical canal and uterine cavity, and 3,000 mgm. hours to the vaginal portion of the cervix. The patient withstood the procedure without untoward symptoms and was discharged from the hospital upon March 1, 1938. In June, 1938, the microscopic examination of tissue excised from the posterior lip of the cervix showed a chronic cervicitis but no evidence of malignancy.

---

*From the Department of Obstetrics and Gynecology, Yale University School of Medicine

Since her discharge from the ward in March, 1938, the patient has been followed at the usual intervals in the Tumor Clinic. Her weight has been retained and when seen upon Aug. 9, 1940, two years and nine months from the date of her first admission, her general condition was excellent. She has neither pain, bleeding, nor discharge. The pelvic structures are freely movable and so far pelvic examination reveals no evidence of recurrence of the tumor. Subsequent examinations will determine the ultimate result of the treatment employed.

Comment

The association of cancer of the cervix and pregnancy is not commonly seen and in the case in question it is highly probable that the malignant lesion preceded gestation. In this connection it is of interest to note that the patient sought medical advice because of the bleeding which alarmed her, but which she regarded as a symptom of a beginning abortion. Fortunately, her attending physician made an immediate diagnosis of malignancy of the cervix and referred her at once to the hospital for treatment.

——☆☆——

DOCTOR VERDI HONORED

On November 12, Doctor William F. Verdi of New Haven was awarded the Gold Medal Award of Merit by the New Haven Advertising Club. The award was made by Governor Baldwin at a testimonial dinner attended by 600 of Doctor Verdi's friends. Speeches were made and Doctor Verdi accepted the honor with exceeding grace, attributing his rise to fame as much to his New Haven environment as to any other factor. The following editorial from a local newspaper is a fitting tribute:

Dr. William F. Verdi

New Haveners have never kept secret their deep respect and sincere affection for Dr. William F. Verdi. No banquet and no award is needed to mark the almost unique position of this man in this community, to express the appreciation of the entire city for the lustre he has brought its name by his scientific achievements and the service incalculable in terms of lives saved and suffering eased by his work here. He has the full trust and the warm-hearted admiration of his fellow New Haveners every day of every year. But such an occasion as the presentation last night of the Gold Medal Award of the New Haven Advertising Club can underline that admiration with eloquent emphasis and offer a tangible token of the high regard in which he is held.

The story behind this year's choice is in itself evidence of its accuracy. Here and there interested persons were quietly discussing the inevitability of the man for the award months before a decision was to be made. They felt that they should wait until the close of the drive to raise funds for the addition to St. Raphael's Hospital before presenting his name. The choice could then be both a tribute to his long career here and to his unselfish service as leader of that campaign. But before they made a move in that direction, they were surprised to hear that the Advertising Club committee had already reached a decision — and Dr. Verdi was the man. The immediate reaction proved as never before the complete rightness of that choice. The rush to make reservations among those who wished to pay tribute by their presence at the dinner last night far surpassed that of previous years. If all who wished to be there could have been accommodated, the Yale Bowl would have had to be commandeered.

This plan of making an annual award of merit was an excellent idea at the start and has steadily improved in practice. Though it was sponsored by one organization, it has become a true community expression of gratitude to outstanding citizens. With Dr. Verdi, the Advertising Club extends the scope of the plan. The former awards have had a distinct artistic, even literary, flavor. Now the award goes to a scientist, not one who works in the cool regions of scientific theory, but a great doctor and surgeon who has proved himself equally supreme as a practicing physician and as pioneer in improving his profession. By honoring Dr. William F. Verdi, the Advertising Club and all New Haven strengthens and pushes forward a fine tradition.

The Connecticut State Medical Journal

Owned and Published Monthly by
The Connecticut State Medical Society.

EDITORIAL BOARD

Stanley B. Weld, *Editor-in-Chief,*	Hartford
Sidney G. Davidson,	New Haven
Frank Stafford Jones,	Hartford
Charles Mirabile,	Hartford
Oliver L. Stringfield,	Stamford
Herbert Thoms,	New Haven

COUNTY NEWS EDITORS

Fairfield — Paul Harper, Bridgeport
Hartford — Benedict B. Landry, Hartford
Litchfield — Francis A. Sutherland, Torrington
Middlesex — William M. Joyce, Middletown
New Haven — Clarence L. Robbins, New Haven
New London — Willard J. Morse, New London
Tolland — Donald M. Beckwith, Rockville
Windham — Edward J. Ottenheimer, Willimantic

Single Copies, 50 cents — Subscription, $4.00 per year

MANUSCRIPTS.—Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

Used manuscript will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS.—Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS.—All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS.—Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS.—Reprints of papers and obituaries may be obtained from the Editor at cost.

• Editorials •

GET OFF THE CRACKER BARREL!

Now that the smoke from the presidential contest has cleared away and with it have vanished traces of some of the emotional crudities of our democracy, we may well contemplate what the future holds for the practice of medicine in this country. The defeatist attitude is all too prevalent. Rumblings of the threat of dictatorship and of the downfall of our democracy, be they fact or fancy, cannot be denied. To the careful student of trends and developments in the United States during the past ten years the presidential election of 1940 is no surprise. Living as we do in the midst of these social and economic changes it is difficult for most of us to get the proper perspective and realize that actually a social and economic evolution is taking place about us. Some of our professional friends have been heard to express themselves as confident that there is nothing in the future practice of medicine which should appeal to their sons as they become eligible.

There is no surer way to strike a fatal blow at democracy and at those principles which are undergoing the test than this attitude of defeatism. Dictatorship in the United States can never materialize unless public opinion becomes throttled. Never has the practice of medicine offered more varied fields of opportunities to a young man than it does today. We have been told in a recent address by our President that there will be no socialized medicine in this country, that government and profession are uniting in efforts to improve medical care. Few seem to realize that many of the principles of socialized medicine already exist and, whether we like them or not, they must be jealously guarded by the medical profession or surrendered to government control. This alone should challenge us.

With enforcement of the Selective Service Act, with the postponement, for the present at least, of prosecution of the federal suit against organized medicine, and with the appointment by our President of the Health and Medical Committee of the Council of National Defense, the picture is not as black as some would like to have us believe. The profession is receiving an unprecedented recognition in the operation of the Selective Service Act. Advice has been freely sought at Washington from organized medicine and the voice of the profession is becoming more authoritative in the halls of our present administrative bodies. Should a future attempt be made to thrust upon our people compulsory health insurance, as some still predict, we shall have secured a tenable position at Washington which may bring about closer cooperation between the government and the medical profession. The postponement of the federal suit against organized medicine may have been but a diplomatic move but as such will develop to our own advantage. Whatever way we turn deep and far reaching changes are taking place in our democratic mode of living. Naturally the practice of medicine is not immune. The opportunities for leadership afforded our profession have presented themselves so rapidly that it is with difficulty that we keep our field of vision clear and our processes of thinking unclouded by the inconsequential and irrelevant; but this must be done.

——☆☆——

CARE OF THE PREMATURE INFANT

Great advances have been made in recent years in reduction of infant mortality. There has, however, been very little reduction during the first month of life and practically none for the first day after birth. Approximately 15% of neonatal deaths are due to congenital malformations and therefore unavoidable. 46% of the deaths during the first month of life are of premature infants. Figures from the Children's Bureau indicate that there are approximately 85,000 premature infants born yearly, and that in 1936, the latest year for which such information is available, 32,452 deaths in the first month of life were reported as due to premature birth.

Out of a total of 75,000 babies who die each year in this country, 56,000 or 81% die as a result of causes arising during pregnancy or at the time of delivery. 69,000 die in the first month of life, 54,000 under one week, 32,000 under one day.

It will be seen, then, that the most urgent need in further reducing infant mortality is to prevent premature birth and all other complications of pregnancy which are avoidable, by better care of mothers during pregnancy and during labor, and better care of the new born infant.

In the care of the premature infant certain principles have been emphasized in the literature for the past thirty years or more. The principles are still the same, only the technique of carrying them out having changed with improved modern equipment now available.

These principles are: maintenance of body temperature, proper feeding, and protection from infection.

When the baby is born the proper equipment should be at hand for his adequate and immediate care. The baby should be delivered in a warm blanket and immediately placed in a warmed bassinet. If there is any mucous or obstruction in the respiratory tract the trachea should be milked holding the baby upside down and the material which is not expressed in that manner should be removed by gentle suction. If after all obstruction has been removed from the upper respiratory tract the baby is not breathing properly, artificial respiration should be employed. Artificial respiration may be given manually, or with some of the newer safe respiratory machines which have been devised, or by proper tracheal insufflation.

One of the most important helps in preventing the death of premature babies is an experienced, well-trained personnel in charge of the babies continuously. A well-trained premature baby nurse is able to sense changes in the condition of the baby and care for them promptly and efficiently, whereas one not used to these delicate infants may wait until too late to apply the proper corrective preceedures in an emergency.

Three things must always be kept in mind by the premature nurse: *One* — maintenance of even body temperature. *Two* — removal of mucous by gentle suction whenever it occurs. *Three* — the giving of oxygen for cyanosis.

Environmental control is most important. In some hospitals there are specially constructed premature rooms where the temperature and humidity are constant. In others, as in the Waterbury Hospital, there is a special room with constant temperature but not constant humidity. In this type of room humidity must be maintained at the proper level by the use of an incubator. The ideal humidity for the premature baby is 65°. The ideal room temperature should be about 80° and the temperature of the incubator anywhere from 80° to 95°, depending on the need of the particular infant.

Prevention of infection is one of the chief items to be considered. This may be avoided by having a separate room for the premature, wearing of gowns and masks, washing of hands properly. Individual equipment should be used for bathing and feeding. Proper arrangements must be made for disposal of soiled diapers and linens. Exclusion from the premature room of all attendants, including nurses and doctors with infections, and of course exclusion of all others.

It is more important at all times to have continous inspection of the baby. Choking from mucous resulting in cyanosis may occur with no warning and unless someone is there to administer proper treatment the baby's life may be lost.

It has been found that in small premature infants gavage feeding is often a life saving measure. Breast milk is the food of choice.

These are some of the essential procedures in the care of the premature infant, and if strictly adhered to should help to lower the mortality rate of this group.

J. H. R.

☆☆

THE PRESERVATION OF SERVICEABLE HEARING

With the evidence gradually accumulating that most of the deafness seen in adult life is the result of damage to the hearing mechanism done by previous infection, particular care must be taken during the winter season to treat these infections with this in mind. The most important causes for loss of hearing are the sequelae of upper respiratory infections which are so prevalent in this part of the country.

With the development of medical specialties, it has been natural to assume that those interested in special fields are best equipped to handle diseases confined to those specialties. However, treatment of infections without special regard for the physiological processes involved may make the patient feel somewhat more comfortable temporarily, but in many cases actually does prolong the course of the disease. As a specific example of this, the treatment of respiratiory infections by thwarting the processes by which these infections are so well-handled by the human body cannot be condoned in the light of modern medical practice.

As a severe ear infection which later leads to deafness follows the upper respiratory diseases which occur during the winter months, it is of special interest as physicians that patients receive proper advice in the early stages of coryza. Appreciating then that nature's method of eliminating infection follows a very definite and logical course, we must not unduly interfere with this process. I refer particularly to the use of the vaso-constrictors in the nose during the early stages of a head cold. Temporary comfort is of importance in the treatment of any patient, but there are other ways of obtaining this rather than making the nose a passage for air. The swelling which occurs in the nose during head colds is a very important part of the protective mechanism and should be encouraged rather than the opposite. The vaso-constricting drugs drive away the very elements which have been so beautifully provided by nature to overcome the infection. The dryness of the mouth which many people experience upon arising in the morning is a small price to pay for a constantly alert natural process which must cause nasal obstruction to function properly.

It is the prolonged upper respiratory infection when the sinuses are involved and later the ears that lead to the ravages attendant upon this unfortunate sequence of events. The fact that most upper respiratory infections eventually do heal spontaneously in spite of the treatment which frequently delays a return to health is the chief reason for encouraging nature in the process which he does so well. The anti-pyretic drugs and barbiturates should be used freely instead of local use of medication in the nose which have not detrimental effects there on the nasal mucosa, but other effects on the neuro-vascular system which should be avoided.

The treatment of upper respiratory diseases constitutes a large portion of medical practice during inclement weather. A rational plan for the care of these patients during the coming winter should be a regime which will eliminate the infection at the earliest possible moment rather than give the patient immediate comfort in the region where discomfort must be present for a short while as an important stage in the best methods now known for a cure.

N. C.

☆☆

CONNECTICUT MEDICAL EXAMINING BOARD

Although there may be those who still think it to be the function of a super bureau of the government, it is likely that the protection and preservation of the health of our people will be left to doctors of medicine for some time to come. Medical service is what physicians supply to the public and the quality of that service exactly parallels the quality of the physicians who render it. There is but one place where that quality may be determined, one place where the public is protected from inadequately trained physicians. It is the licensing examination of the Connecticut Medical Examining Board. That Board is the first, and almost the only line of defense the public has to protect the quality of its medical care. If the Board lowers its standards or relaxes its vigilance the whole complex structure of medical service is weakened.

The Connecticut State Medical Society may review with satisfaction the results of its efforts to improve and strengthen the process of medical licensure. One hundred years ago, long before any state thought of requiring a license to practice, the Connecticut State Society required all candidates for membership to pass an examination before the Society's board. During the 1880's the Society began its effort to require a license from the State. This culminated, in 1892, with the passage of the first medical practice laws. From 1892 to 1925 the State entrusted to the Society the responsibility for examining candidates and recommending them for licenses. In 1925 the Society sought revision of the laws so that the standards might be elevated. With the passage of the 1925 amendments the Connecticut Medical Examining Board became an official state agency appointed by the Governor on nomination by the Society.

The Board has served the people of this State with fine diligence and integrity and has for fifty years been a safeguard to the quality of medical care. The failure rate before the Connecticut Board is high. For the five years just ended 28.01% of the candidates who appeared before the Board failed to pass the examinations, a rate that is exceeded by only one State in the nation and in that State an unusual circumstance exists.

The time has now come when further revision of the law is desirable. There have been changes in the pattern of medical education; standards that seemed high a decade or two ago are no longer adequate; migratory physicians and graduates of little-known foreign schools have brought new problems that the present statutes cannot fully meet and if the Board is to continue its great public usefulness it needs a better law behind it.

The proposed changes involve four Sections of the General Statutes. They have been written in consultation with the Bureau of Legal Medicine of the American Medical Association and have been carefully reviewed by many groups. The proposed revisions are published elsewhere in this issue and comments from members of the Society are invited.

C. B.

☆☆

FOUR SCORE AND TEN — PLUS TEN

"More Years For the Asking" is written with the hope that its pages may reach an hundred thousand people, and that to each may be given at least ten additional years of life. The author, Doctor Peter J. Steincrohn, a practising physician in Hartford, states the purpose of his book in a few words, "to teach a philosophy of life." This most readable and complete volume is intended for the laity, to inform them in simplest terms how to recognize danger signals and, what is more important, to heed them early. The author is in no sense an alarmist, but now that the curtain of reticence, yes, of secrecy, has been in a large measure lifted from many fields of medicine, it is becoming increasingly evident that the sick desire to learn more about the true nature of their malady. This fact should be faced fairly and honestly, and in most cases a truthful statement of conditions and plans for cure should be given.

We have stated that this book is written primarily for the patient, actual or potential. Chapter twelve is one for the doctor himself to chuckle over as he sits in his comfortable armchair in an endeavor to relax between calls and hopes for his own well merited four score and ten. We commend the book for your own perusal and for your patients' thoughtful study.

☆☆

TRIBUTE TO HANS ZINSSER

The Harvard Medical Alumni Bulletin for October 1940 carries a supplement containing addresses delivered at the memorial exercises held at the Medical School for the late Doctor Hans Zinsser. It is a fitting tribute to this great scholar, modest as he was, yet testifying to his far reaching influence in a world fraught with difficult medical problems which but stimulated him to greater endeavor when he realized his days were numbered.

☆☆

M.D. AUTOMOBILE LICENSE PLATES

The State Commissioner of Motor Vehicles still has available a number of automobile license plates bearing the designation "M.D," with numerals. The Motor Vehicle Department is limiting the issuance of these markers to physicians. Members of the Society who would like to exchange their present markers for a set of these are invited to communicate with the Commissioner of Motor Vehicles, Hartford.

☆☆

HAVE YOU ANOTHER REPRINT?

Many of the members of our Society have published articles in leading medical journals throughout the country during the past year. A list of such will be published in the January issue of the *Journal.* The Army Medical Library has provision for maintaining a collection of these reprints, properly catalogued, and available for reference. This collection at Washington thus forms a ready bibliography of the work of any given writer and a valuable source of supplementary material when the volume of original publication is temporarily unavailable at the bindery or on loan. In mailing reprints of your papers do not overlook the Army Medical Library, Washington, D. C.

☆☆

TRIAL POSTPONED INDEFINITELY

Referring to the trial of the American Medical Association and certain of its officials for alleged violation of the Sherman Anti-Trust Laws, scheduled to start in Washington, D.C., on Oct. 21, *The Journal* of the Association in its Oct. 26 issue says:

"According to an announcement issued in Washington on October 17 by United States Attorney Edward M. Curran, Justice W. Morris, who is presiding in Criminal Court No. 2 of the District Court, disqualified himself from sitting on the case because of his former connection with the Justice Department as assistant attorney general. Justice F. Dickinson Letts, now presiding in Court No. 1, is in the middle of a first degree murder case and has a heavy assignment for the next few weeks. 'Since no third criminal court is available at the present time,' said United States Attorney Edward M. Curran, 'I have taken the case off the assignment and it will be set down for trial in the future on a date agreeable to both the government and the defense.'

"This postponement will release the officials of the Association, therefore, to a continuation of their work in the headquarters office and in other capacities so essential particularly at the present time."

☆☆

DEDICATION OF NEW SOUTHBURY TRAINING SCHOOL

On November 9 Governor Baldwin dedicated Connecticut's new state training school for mental defectives at Southbury. The *Journal* for November 1940 carries an excellent description of the school by its superintendent, Ernest H. Roselle. Doctor Grover F. Powers of New Haven has been a member of the Board of Trustees since its formation and Doctor Herman Yanett has just been appointed Medical Director of the School. Both Doctors Powers and Yanett are members of the Connecticut State Medical Society.

Clinical Congress to Sponsor Post Graduate Courses

In announcing two post graduate courses of instruction, the Committee on the Clinical Congress is carrying out its function as outlined in the by-laws of the Connecticut State Medical Society. In section 8 of Chapter VIII of these by-laws the Committee is charged with the "arrangement and direction of the annual Clinical Congress of the Society and such other activities in post graduate instruction as may from time to time appear desirable to the Committee."

The program committee under the chairmanship of Doctor Louis H. Nahum has organized two courses which are offered this year. These are in Industrial Medicine and Diseaes of Nutrition. The former is certainly of tremendous importance in our state and the second covers a field already important and with possibilities of vastly greater moment in the future. A short glance at the subjects, printed below, will indicate the wide appeal these should have to every member of the profession whether he is a general practitioner or a specialist.

The courses will be given at The Yale School of Medicine on Thursday afternoons. Each will consist of fourteen lectures, the first being given on Thursday, January 9, 1941 and continuing at weekly intervals through April 10, 1941.

The lecturers who have been invited to take part in these courses have been chosen because of their recognized ability to speak with authority upon the individual topics and include besides members of the faculty of the Yale School of Medicine many authorities from other states.

In order to defray the expenses of organizing and conducting these courses there will be a registration fee of three dollars ($3.00) for each course. Physicians may register for either one or both courses.

Diseases of Nutrition		Industrial Medicine
Surgical Auditorium Farnam Memorial Building 3:00 P.M.		Surgical Auditorium Farnam Memorial Building 4:00 P.M.
Dr. Fuller Albright, Dr. W. B. Castle, Dr. Alice Cattanach, Dr. G. R. Cowgill, Dr. M. Heinemann, Dr. Norman Jolliffe, Dr. P. H. Lavietes, Dr. C.N.H. Long, Dr. J.P.Peters, Dr. A. White, Dr. A. Winkler, Dr. H.M. Zimmerman		Prof. C. E. A. Winslow Hon. Louis Sachs, Dr. Leonard Greenburg, Dr. Paul Vestal and others to be announced later.
The Nature and Functions of Dietary Constitutents	January 9, 1941	Ventilation in Industry and for the Practicing Physician
	January 16, 1941	Pulmonary Diseases due to Dust
Carbohydrate Inter-relationships	January 23, 1941	Infections in Industry

Protein and Fat Deficiencies	January 30. 1941	Dermatitis and Carcinogenic Substances
	February 6, 1941	Poisoning by Benzol—Other Industrial Solvents
General Characteristics and Properties of Vitamins — The Problem in Man	February 13, 1941	Carbon Monoxide Poisoning and Other Irritant Gasses
Water, Sodium, Iodine, Potassium and Magnesium in Health and Disease	February 20, 1941	Lead Poisoning
	February 27, 1941	Poisoning by Other Heavy Metals
Calcium, Phosphorus and Vitamin D	March 6, 1941	Caisson Disease and Diseases Due to Changes in Atmospheric Pressure
Vitamin B Deficiency	March 13, 1941	Cardiac Diseases in Industry
Vitamin A, C, K, (P)	March 20, 1941	Adequate Nutrition for the Industrial Worker
Iron and Hematopoietic Factors	March 27, 1941	Medical and Health Services in Industry
Pathology of Dietary Deficiencies	April 3, 1941	Preventive Industrial Medicine
The Calculation of Diets	April 10. 1941	Legal Aspects of Occupational Diseases

Applications for registration in these courses should be sent now to The Connecticut Clinical Congress, 258 Church Street, New Haven, Connecticut.

Tear Here

CONNECTICUT CLINICAL CONGRESS,
258 Church Street, New Haven, Connecticut

Enclosed find my check for
$3.00 (for one course)
$6.00 (for both courses)

as registration fee for post graduate course in

( ) Diseases of Nutrition
( ) Industrial Medicine

Name

Address

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street New Haven

THE COUNCIL MEETS

The Council met for its monthly meeting on November 6. There were present: James R. Miller, Chairman; Samuel F. Mullins, Edward J. Whalen, Charles H. Turkington, Thomas P. Murdock, George H. Gildersleeve, Charles T. LaMoure, Robert C. Paine, George Blumer, Stanley B. Weld, Hugh B. Campbell and Creighton Barker. Absent: Alfred N. Sweet. Several recommendations were made for action at the special meeting of the House of Delegates to be held on December 12th which will be found elsewhere in this issue. The Council also voted to appoint Doctor Joseph I. Linde, ex-president of the Society, to be the representative to the Connecticut Tuberculosis Association.

NEW MEMBERS
THE CONNECTICUT STATE MEDICAL SOCIETY

Fairfield County

Mary Adams, Armstrong Avenue, Riverside, Johns Hopkins 1929

Joseph Patrick Connolly, 79 Warren Street, Stamford, Georgetown 1936

James Everett Crane, 50 Glenbrook Road, Stamford, Vermont 1939

Leonard Arnold Howard, 87 West Street, Danbury, Louisiana State 1939

Benjamin Reynolds Reiter, 144 Golden Hill Street, Bridgeport, Harvard 1934

William B. Swarts, 1 Atlantic Street, Stamford, Univ. of Pennsylvania 1934

Harry Morgan Tiebout, "Blythewood," Greenwich, Johns Hopkins 1921

By Transfer:

William Frederick Green, Fairfield State Hospital, Newtown, Harvard 1932

Hartford County

John James Clancy, 50 Farmington Avenue, Hartford, Yale 1935

Albert Elmer Diskan, 869 Main Street, Manchester, Temple 1937

Gilbert Whipple Heublein, 179 Allyn Street, Hartford, Univ. of Pennsylvania 1939

Joseph Francis Jenovese, 179 Allyn Street, Hartford, Univ. of Pennsylvania 1930

Newell Raymond Kelley, 23 Riverview Road, Rocky Hill, Harvard 1937

Joseph John Lankin, 525 Main Street, Hartford, Harvard 1937

Anthony Victor Nevulis, 140 Main Street, New Britain, Vermont 1938

Arthur Felix Roche, 50 Farmington Avenue, Hartford, Georgetown 1917

Paul Dolin Rosahn, 92 Grand Street, New Britain, N. Y. U. 1928

William Beecher Scoville, 179 Allyn Street, Hartford, Univ. of Pennsylvania 1932

Anthony Shupis, Jr., 444 Park Street, Hartford, Hahnemann 1938

Gershon Benjamin Silver, 449 Albany Avenue, Hartford, Tufts 1937

Maurice D. Spottswood, 200 Retreat Avenue, Hartford, Georgetown 1936

Thaddeus James Valenski, Main & Pearl Streets, Thompsonville, Tufts 1937

Henry Stanley Warren, 184 Main Street, Wethersfield, Harvard 1936

By Transfer:

Lyman Rogers Morse, "Cedarcrest," Hartford, Queens 1926

Raymond Lester Osborne, 200 Retreat Avenue, Hartford, Columbia 1936

Litchfield County

Raymond Dunsmore Markle, Pleasant Street, No. Woodbury, Syracuse 1937

Middlesex County

Richard Francis Grant, 221 Main Street, Cromwell, Albany 1938

By Transfer:

John T. Powers, Central National Bank Building, Middletown, Physicians and Surgeons, Baltimore 1910

New Haven County

Benedict Biondi, 1593 Chapel Street, New Haven, Tufts 1938

Warren Thompson Brown, 333 Cedar Street, New Haven, Texas 1933

Michael Joseph Carpinella, 48 Kirkham Street, Branford, Rochester 1932

Samuel Meyers Dreher, 282 Main Street, Derby, Temple 1937

George Graham Fox, 147 West Main Street, Meriden, Harvard 1934

Irving Friedman, 315 Whitney Avenue, New Haven, Yale 1933

John Winslow Hirshfeld, 789 Howard Avenue, New Haven, Cornell 1934

Charles Stephen Kennedy, 175 Meadow Street, Naugutuck, Georgetown 1930

Leo William Koster, 354 Campbell Avenue, West Haven, N. Y. U. 1937

Roger Burdette Nelson, 24 Central Avenue, Waterbury, Cornell 1934

Joseph Francis Sadusk, Jr., 789 Howard Avenue, New Haven, Johns Hopkins 1935

John Elias Stoddard, 119 West Main Street, Meriden, Boston Univ. 1904

Lewis Thorne, 109 College Street, New Haven, Yale 1936

Leo Louis Tylec, 359 North Main Street, Union City, Virginia 1935

James Sipple Van Leuvan, 61 Colony Street, Meriden, Yale 1927

Carl Philip Viola, 2½ Broad Street, Milford, Tufts 1936

Frank DeStasio, 434 Temple Street, New Haven, Maryland 1933

New London County

Report not received.

Windham County

Andrew Olavi Laakso, 27 Broad Street, Danielson, Cornell 1937

* * *

COMMITTEE ON SESQUICENTENNIAL CELEBRATION HAS FIRST MEETING

The Committee to make arrangements for the celebration of the 150th anniversary of the Society had its first meeting at the Hunt Memorial in Hartford on the 29th of October. Doctor Blumer, the Chairman, presided and there were present: George Blumer, C. Brewster Brainard, D. Chester Brown, Ernest J. Caulfield, James D. Gold, Samuel C. Harvey, Arthur B. Jackson, Alfred Labensky, Michael J. Lawlor, Roy L. Leak, Robert J. Lynch, Michael J. Morrissey, Maurice T. Root, Peter J. Steincrohn, Daniel L. Sullivan, Herbert Thoms, Stanley B. Weld, Benedict N. Whipple and Creighton Barker; absent: Francis H. Burke, Cecil R. Garcin, Cole B. Gibson, Crawford Griswold, Charles S. Knapp, Louis H. Nahum, George M. Smith and Walter R. Steiner. The general plan for the celebration, which is to be held in Middletown in 1942, was discussed by many members of the Committee. No definite program for the meeting was evolved but a vote of those present showed that opinion unanimously favored an historic meeting rather than a scientific and clinical program.

It was voted to authorize the Chairman to appoint a planning committee consisting of five members of the General Committee and the Chairman of the Council, the Executive Secretary, the Editor of the Journal and Chairman of the Sesquicentennial Committee, ex-officio.

A few days after the meeting in Hartford the Planning Committee was appointed; it consists of Herbert Thoms, New Haven, Chairman; James D. Gold, Bridgeport; Roy L. Leak, Middletown; Peter J. Steincrohn, Hartford; Daniel Sullivan, New London; James R. Miller, Chairman of the Council; Stanley B. Weld, Editor of the Journal; the Executive Secretary and Doctor Blumer. This Committee will submit its plans to the General Committee before January 15, 1941. Conferences have already been held by members of the Planning Committee and the Chairman of the Local Committee on Arrangements from Middlesex County Medical Association.

Any member of the Society who has suggestions to offer concerning the program for this important celebration is invited to communicate his ideas and suggestions to the Chairman of the Planning Committee, Doctor Herbert Thoms, 789 Howard Avenue, New Haven.

Special Meeting of the House of Delegates

December 12, 1940

There will be a special meeting of the House of Delegates at the New Haven Medical Association, 364 Whitney Avenue, New Haven, at 4:45 o'clock in the afternoon on Thursday, December 12, 1940. Members of the House of Delegates will be guests of the Society for dinner following the meeting.

The agenda for this meeting is given herewith and no matters of business not included may properly come before the meeting.

1. THE BUDGET FOR 1941

The Council recommends to the House of Delegates the adoption of the following budget and the assessment of dues of $15.00 per member for the year 1941.

Society's Office		
Personal Service	$11,860.00	
Rent	1,020.00	
Postage, printing light, janitor, etc.	1,200.00	$14,080.00
		unchanged from 1940
Journal	$ 3,600.00	$ 3,600.00
		reduced $1200. *from* 1940
Treasurer's Contingent Account		
Miscellaneous increased 500.00 to include Legis. Com. expenses. Approp. of 300.00 eliminated	$ 2,500.00	
Council Expenses unchanged from 1940	200.00	
Council Chairman unchanged from 1940	300.00	
A.M.A. Delegate expense increased 100.00 1941 convention is in Cleveland	200.00	
Secretary's Annuity	$ 1,000.00	
Total		$ 4,200.00
		increase of $300. *over* 1940
Total		$21,880.00
		less than 1940 *budget by* $900.00

2. EXEMPTION FROM DUES FOR MEMBERS IN MILITARY SERVICE.

The Council recommends to the House of Delegates the adoption of the following resolution:

On and after January 1, 1941 members of this Society who are engaged upon full time active duty with the United States Army, Navy or Public Health Service shall, upon their own request, be exempt from payment of dues to this Society for the period that they are engaged upon such full time active duty.

Exemption from payment of dues shall be pro rated upon a monthly basis equal to one-twelfth of the total annual dues assessed by the Society and the period of exemption shall commence on the first day of the month following entrance into full time active service and terminate on the first day of the month following return to a civilian status.

Application for such exemption should be addressed in writing to the Treasurer of the Society, 258 Church Street, New Haven. In the event a member has paid his dues in advance for the year and subsequently enters full time, active, military service, the Treasurer is authorized to remit to that member at the end of the year such part of the dues paid as may cover the time spent in full time active, military service, pro rated upon a monthly basis.

3. LAW REGULATING THE USE OF CONTRACEPTIVES.

The Council recommends to the House of Delegates the adoption of the following resolution submitted by the Society's Committee on Public Health: "After considerable investigation and discussion the Public Health Committee wishes to report to the Council of The Connecticut State Medical Society that in the opinion of the Committee it is inadvisable for the Society to take any action at this time on the contraceptive law. Nothing in this recommendation is to be construed as a limitation or restraint of the rights of any member of the Society as an individual."

4. AMENDMENTS TO MEDICAL PRACTICE ACT.

The Council recommends to the House of Delegates that the Society introduce into the 1941 General Assembly of the State of Connecticut amendments to the Medical Practice Acts of the State of Connecticut as proposed by the Connecticut State Medical Examining Board. (The proposed new laws are published on the following page of this issue).

5. NEW ENGLAND POSTGRADUATE ASSEMBLY.

Discussion and action upon the Society's participation as a sponsor of the New England Postgraduate Assembly

THE HOUSE OF DELEGATES

The President of the Society
The President-Elect of the Society
The Executive-Secretary of the Society
The Treasurer of the Society

Councilors

J. D. Gold, Fairfield
E. J. Whalen, Hartford
C. H. Turkington, Litchfield
A. N. Sweet, Middlesex
T. P. Murdock, New Haven
G. H. Gildersleeve, New London
C. T. LaMoure, Tolland
R. C. Paine, Windham

Elected Delegates

Fairfield County

H. L. Amoss, Greenwich
E. C. Beck, South Norwalk
J. G. Booe, Bridgeport
R. A. Gandy, Stamford
D. F. Keegan, Bridgeport
R. A. Keedy, Stamford
F. M. Meyer, Bridgeport
O. L. Stringfield, Stamford
W. A. Sunderland, Danbury
F. F. Tomaino, Danbury
E. J. Wales, Monroe

Hartford County

L. Antupit, Hartford
F. S. Bird, Bristol
T. F. Brewer, Hartford
B. B. Earle, Glastonbury
E. C. Higgins, South Manchester
A. Kilbourn, Hartford
W. T. Morrissey, New Britain
F. T. Oberg, Hartford
R. H. Osmond, Hartford
A. P. Pratt, Windsor
C. T. Schechtman, New Britain
P. J. Steincrohn, Hartford
E. J. Turbert, Hartford
S. B. Weld, Hartford
T. W. Worthen, Hartford
E. J. Zaglio, Manchester

Litchfield County

F. A. Sutherland, Torrington
W. B. Walker, Cornwall
C. N. Warner, Jr., Litchfield

Middlesex County

J. W. Fisher, Middletown
W. N. Nelson, Cromwell

New Haven County

C. J. Bartlett, New Haven
G. Blumer, New Haven
P. J. Brennan, Waterbury
T. S. Evans, New Haven
W. J. H. Fischer, Milford
C. B. Gibson, Meriden
W. E. Hall, Meriden
A. E. Herrmann, Waterbury
R. J. Hinchey, Waterbury
R. E. McDonnell, New Haven
L. H. Nahum, New Haven
J. H. Root, Waterbury
C. E. Sanford, New Haven
F. N. Sperry, New Haven
A. C. Swenson, Waterbury

New London County

A. C. Freeman, Norwich
J. G. Raymer, Norwich
S. H. Baron, New London
T. Soltz, New London

Tolland County

F. H. Burke, Rockville

Windham County

R. L. Gilman, Storrs
W. M. Shepard, Putnam

Proposed Changes Connecticut Medical Practice Act

The Society's Committee appointed to recommend the revision of the Medical Practice Acts proposes that the statutes be amended to read as given below. Comments or suggestions with respect to these proposals may be addressed to the Secretary's office.

SUSPENSION, REVOCATION OR ANNULMENT OF LICENSE

Sec. 2741.

The license or certificate of registration of any licensed or registered practitioner of the healing art in this State may be revoked, suspended or annulled or such practitioner may be reprimanded or otherwise disciplined, after notice and hearing, on the recommendation of the examining board representing the branch of the healing art practiced by such practitioner for any cause named below. Proceedings relative to the revocation, suspension or annulment of a license or certificate of registration or toward disciplinary action shall be begun by the filing of written charges, verified by affidavit, by the State Department of Health with the examining board representing the branch of the healing art practised by the practitioner.

The causes for which a license or certificate of registration may be revoked, suspended, or annulled or for which a practitioner may be reprimanded or otherwise disciplined are as follows:

(a) Conviction in a court of competent jurisdiction, either within or without this State, of any crime involving moral turpitude, of any crime in the practice of his profession, of any felony or of any misdemeanor;

(b) Immoral, fraudulent, dishonorable or unprofessional conduct;

(c) Illegal, incompetent or habitually negligent conduct in the practice of the healing art;

(d) Habitual intemperance in the use of spirituous stimulants or addiction to the use of morphine, cocaine or other habit-forming drugs;

(e) Advertising in connection with the practice of the healing art which is found by the board representing the branch of the healing art practiced by the practitioner to be deceptive, misleading, extravagant, improbable or untrue;

(f) Aiding or abetting the unlawful practice of any branch of the healing art;

(g) Failure to record a license or certificate of registration as required by law;

(h) Insanity of the practitioner;

(i) Fraud or deception in obtaining a license or certificate of registration.

The clerk of any court in this State in which a person practicing any branch of the healing art is convicted of any crime as described in this section shall immediately after such conviction transmit a written report thereof, in duplicate, to the State Department of Health, containing (1) the name and address of the practitioner, (2) the crime of which he was convicted, (3) the date of conviction, and (4) the branch of the healing art practiced by such practitioner designating the examining board representing the branch of the healing art practiced by such person, the written charge being accompanied by a copy of the report of the clerk of the court.

HEARING OF CHARGES AND REVOCATION

Sec. 2742.

On receipt of a written charge, verified by affidavit, filed by the State Department of Health, the examining board shall transmit a copy thereof to the practitioner named therein and shall at the same time notify such practitioner of the place where a hearing will be held by the board on the charge and of the time of such hearing which shall be not less than ten days after the service of such notice. If a personal service on the practitioner or his counsel cannot be had, the secretary of the board shall cause to be published on three different days, at least thirty days prior to the hearing, a notice of the time and place of the hearing in a newspaper published in the county in this State in which such practitioner was last known to reside. A copy of the notice so published shall be sent by registered mail to the practitioner at his last known address.

The practitioner against whom a charge is filed shall have a right to a hearing before the board having jurisdiction, may appear in person or by counsel, or both, may produce witnesses and evidence in his behalf, and may question witnesses. The board may subpoena witnesses and papers on its own behalf and, if requested by the practitioner, may subpoena witnesses and papers in his behalf, may administer oaths, may compel the testimony of witnesses and may examine witnesses. It may issue commissions to take testimony and the testimony so taken and sworn to shall be admissable in evidence for and against the practitioner.

The Attorney General shall, upon request, furnish legal assistance to the board.

If the board, by a majority vote of its members shall find the practitioner guilty of any of the charges preferred against him, it may, in its discretion, by written notice to the practitioner, reprimand or it may otherwise discipline him, or it may recommend to the State Department of Health, in writing, that the certificate of registration of the practitioner be revoked or that it be suspended for a period of time to be set out in the recommendation. If the practitioner shall be found not guilty, the board shall order a dismissal of the charges.

Upon receipt of a recommendation, as herein provided, that a certificate of registration be revoked or that it be suspended, the State Department of Health shall issue a revocation or suspending order, as the case may be, in compliance with such recommendation. One copy of such order shall be sent by registered mail to the practitioner at his last known address and one copy shall be mailed to the town clerk of the town wherein the practitioner last resided. Such town clerk shall record such order in a book provided by the State Department of Health for the recording of certificates of registration and shall make a memorandum on the page where such practitioner's certificate of registration has been recorded, stating the book and page where such order of revocation or suspension has been recorded.

REQUIREMENTS FOR REGISTRATION

Sec. 2747.

Except as hereinafter provided, no person shall receive a certificate of registration under the provisions of Sec. 2746 as amended, until he shall have passed an examination before one of the examining boards appointed for such purpose by the Governor, nor until he shall have filed with the State Department of Health a statement in duplicate, signed by a majority of the members of such Board, certifying to the fact that the person named therein has been found qualified to practice medicine and surgery and, in addition, a statement on a blank form furnished by said Department, subscribed and sworn to by the applicant, embodying his name, age, place of birth, the medical school from which he is a graduate, the date of his graduation and such other information as the blank form may call for.

Each applicant for a certificate of registration shall, in addition to presenting a certificate as required by Sec. 2736, as amended, submit proof satisfactory to the examining board having jurisdiction that he:

(1) is not less than 21 years of age;

(2) is of good moral character, certified to by two reputable citizens of this State;

(3) is a citizen of the United States;

(4) is either a resident of this State, or intends in good faith permanently to reside in this State, or is a teacher in a medical school located in this State approved as provided in Sec. 2749 as amended;

(5) has been a resident student through not less than four graded courses of not less than 32 weeks each in a medical school or schools approved as provided in Sec. 2749 as amended and has received a diploma of graduation from such a school;

(6) if a graduate from such an approved medical school subsequent to January 1, 1919, has completed before beginning the study of medicine a course of study of an academic year consisting of not less than 32 weeks' duration in a college or scientific school approved by such board and which course included the study of chemistry, physics and general biology; and

(7) if a graduate from an approved medical school subsequent to July 1, 1947, has completed before beginning the study of medicine a course of study of two academic years of not less than 32 weeks' duration each in a college or scientific school approved by such board, which course included the study of chemistry, physics and general biology.

In lieu of the examination herein required, any of the examining boards appointed under the provisions of Sec. 2748, as amended, may under such regulations as the board may establish accept a license from the board of medical examiners of and State in the United States or the District of Columbia or of any agency in such jurisdictions authorized to issue licenses to practice medicine, provided the applicant (1) obtained such license after an examination of as high grade as that required for a certificate of registration in this State; (2) has been a resident student through not less than four graded courses of not less than 32 weeks each in a medical school or schools approved as provided in Sec. 2749 as amended and has received a diploma of graduation from such a school; (3) is a citizen of the United States and a resident of this State or intends in good faith permanently to reside in this State, or is a teacher in a medical school located in this State approved as provided in Sec. 2749, as amended; (4) has lawfully engaged in the practice of medicine in any state of the United States or in the District of Columbia for a period of three years during the last five years immediately preceding the date of his application hereunder, any part of which period he may have served as an interne in a hospital approved by such board; and (5) is of good moral character and professional standing, as determined by such board. Upon the receipt of $50, the board may issue to such applicant a statement certifying to the fact that the person named therein has been found qualified to practice medicine and surgery.

Furthermore, the board may, on the receipt of the sum of $25, likewise accept and approve, in lieu of the examination herein required, a diploma of the National Board of Medical Examiners, subject to the same conditions set forth in the preceding paragraph except that diplomates of the National Board of Medical Examiners shall not be required to have engaged in the practice of medicine for a period of three years, and may issue to such diplomate a statement certifying to the fact that the person named therein has been found qualified to practice medicine and surgery.

A physician who shall have been graduated from a medical school, considered by the board as being acceptable, who began the practice of medicine outside of this State prior to May 23, 1893, and who shall appear before any of the examining boards appointed under Sec. 2748, as amended, may on the payment of the sum of $50 to such board, receive without examination a statement that the person named therein has been found qualified to practice medicine, if the board shall find that the applicant (1) is a citizen of the United States; (2) is a resident of this State, or intends in good faith permanently to reside in this State, or is a teacher in a medical school located in this State approved as provided in Sec. 2749; as amended, (3) has engaged in the practice of medicine for a period of six months during the year immediately preceding the date of his application; (4) is of good moral character and professional standing, as determined by the board; and (5) has a license authorizing him to practice medicine in the state in which he shall have resided immediately preceding his application.

Any person who shall have complied with the requirements of this section and who shall file the proof thereof with the State Department of Health shall receive from the Department, on payment of $2, a certificate of registration which shall include a statement that the person named therein is qualified to practice medicine and surgery. Each of the examining boards provided for in Sec. 2748, as amended, shall file with the State Department of Health within 30 days after each examination a list of all applicants who have appeared before the Board and the results of their examination.

EXAMINATION

Sec. 2749.

The examining boards provided for by Sec. 2748 as amended shall hold examinations on the second Tuesday of March, July and November of each year, at such places as they may designate and at such other times and places as they shall determine. Each of said boards shall prepare its own questions and shall make rules and regulations for conducting its examinations and for the operation of the board as, from time to time, it shall deem necessary. Each applicant for examination shall be examined by the board representing the same school of practice in which the applicant received his degree in medicine.

Before being admitted to the examination an applicant shall pay to such board the sum of twenty-five dollars and an applicant rejected by an examining board may be re-examined at any subsequent meeting of such board upon payment of the sum of twenty-five dollars for each appearance, provided however that an applicant may not appear before such board more than four times. Upon the receipt of the duplicate statements as provided in Sec. 2747, as amended the State Department of Health shall forward one of said duplicate statements, together with a statement that a certificate of registration has been issued, to the town clerk of the town wherein the person filing such statements resides, and, in case such person shall not reside in this State, the State Department of Health shall hold such statements until notified by such person of the name of the town in this State in which he intends to reside, when said Department shall transmit such statements to the town clerk of such town, and such town clerk shall record the same in a book to be provided for that purpose by the State Department of Health, and shall then return the same to the person who filed such statements with said Department; and such town clerk shall receive for such recording a fee of twenty-five cents to be paid by the State Department of Health from the amount paid to him as aforesaid.

Annually during the month of January the secretary of each of the said examining boards shall file with the State Department of Health a list of approved medical schools or institutions, graduates from which may be admitted to examination before such boards. Such list of approved schools may be revised from time to time at the discretion of the board.

——☆☆——

THE TAR HEELS TALK IN PLAIN LANGUAGE

The action of the State Board of Health of North Carolina in recognizing a medical problem in the need for contraceptive advice is apparent to every thoughtful physician and health officer in the country and putting it in its proper place has served principally to accomplish two purposes in this State.

First, it has encouraged a large number of women of moderate means to consult their physicians more freely for advice and sympathetic assistance; and on the other hand, it has encouraged every thoughtful and conscientious practicing physician in the State to give such patients the same careful attention that he would to any other problem arising in his practice.

There has never been any law on the subject in North Carolina. Physicians in this State have always been free to offer any advice or the use of any methods they thought practical in their practice. . . . . .

In only a few States has there ever been restrictive legislation on the subject. A majority of the States have made no mention in their laws of birth control. The two States which have the most rigid restrictive laws are Massachusetts and Connecticut. The Connecticut law which has recently been approved by a belated appeal to the State Supreme Court stands alone as one of the most drastic and unreasonable laws on any subject ever passed by any American State. It even forbids the private physician in his own office to advise sterilization of a patient or to advise contraceptives when the patient's very life depends on the carrying out of such instructions. *Such a law in the United States at this time is utterly unthinkable.* Had the State of North Carolina even discussed such a law, it would have been held up to ridicule throughout the country. The law is more drastic and much more foolish than the celebrated evolution law enacted in Tennessee some years ago.

The State Board of Health has simply acknowledged the need for a medical and scientific approach in this field and is trying to establish such a program. It is undertaking to bring into the sunlight of medical and scientific procedures things that have been thriving in the back alleys, and in such a course it is bound to promote human welfare and to prevent much unnecessary human suffering.

N. C. Med. Jour., Sept. 1940

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Pavaex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

Connecticut Hospital Association

A REPORT FROM THE NORWALK GENERAL HOSPITAL

After having apparently crowded its building to capacity last year, the Norwalk General Hospital was confronted with a steadily increasing number of patients and gave thirteen percent more days care for the year ending September 30 than during any year in its history. The occupancy for the year was over eighty-nine percent. To accommodate the patients eight additional beds were added during the year, bringing the total capacity up to 201. Space for another eight beds is under construction on the maternity floor which will shortly be put into use. This will raise the capacity for the present fiscal year, including bassinettes, up to 217.

During the year just ended $33,025.00 was spent to increase facilities and to enlarge the intern's quarters.

In the last seven years the Norwalk Hospital has nearly doubled its service to patients, the gain over the 32,966 days care in 1933 being 31,000, or ninety-four percent. During the same period the births increased from 471 to 896, a gain of ninety per cent. The increase in births during 1939 was fourteen percent.

October was one of the busiest months in the history of the hospital, with a twenty-five percent gain in service over a year ago.

Construction has been started on a one story addition to provide facilities for prenatal and postnatal clinics, which will cost approximately $15,000.00. A waiting room, a consultation room and three treatment rooms will be provided. The new facilities become possible through the generosity of the Bedford Fund, which has been helpful to the hospital over many years. Arrangements have been made to consolidate in the new addition, when completed, two prenatal clinics now functioning in Norwalk and South Norwalk.

* * * *

FROM THE CHARLOTTE HUNGERFORD HOSPITAL

The Annual report of the Charlotte Hungerford Hospital has just been issued. In addition to the usual statistical and financial figures, it gives graphs and cuts illustrating the work of the hospital for the year ending June 30, 1940. The report points out that during the nine years the present hospital building has been occupied, 24,751 patients have received 270,156 days care in it. "These patients," the report states, "represent more than 28 per cent of the population of Litchfield County according to the census of 1940."

The annual drive for membership in the Charlotte Hungerford Hospital Auxiliary is now being conducted under the Chairmanship of Mrs. Gustav Broberg. The latest returns indicate that the number of members last year, 1074, will in all probability be increased before the drive is completed.

At the Annual meeting of the Board of Governors of the Charlotte Hungerford Hospital, the following officers were elected: President, Francis H. Griffiths; Vice-president, J. P. Fitzgerald; Secretary, James W. Roraback; Treasurer, John M. Wadhams; Assistant Treasurer, Torrington National Bank and Trust Company. Members of the Board of Governors: Frederick L. Braman, Alfred W. Burg, Howard J. Castle, Dr. B. Austin Cheney, Frank J. Damon, P. J. Fitzgerald, Francis H. Griffiths, W. R. Reid, James W. Roraback, John M. Wadhams, Brigadier General Sanford H. Wadhams. Executive Committee: Messers Griffiths, Chairman, Braman, Damon, Fitzgerald, Roraback, Carlton, H. Talcott and John M. Wadhams.

Editor's Note: We have spent some time trying to determine the reason for the phenomenal increase of service at the Norwalk Hospital, and our conclusions are that it is entirely because of Bob Brough — a fine personality, a hard worker and a man determined to place his hospital in the front ranks. It's a great incentive to have a colleague of this type and our congratulations go wholeheartedly to him.

FROM THE LITCHFIELD COUNTY HOSPITAL

The appointment of Mr. H. N. Morford as Director of the Litchfield County Hospital at Winsted has been recently announced. Mr. Morford who has been superintendent of Prospect Heights Hospital, Brooklyn, N. Y. since 1934 will assume his duties on December first. Mr. Morford comes to the Winsted Hospital after many years of administrative experience. It is anticipated that the new director will make valuable contributions to the hospital problems of Litchfield County and of the State.

* * * *

WAR AND THE DRAFT

Doctors. Today young men studying for the profession of medicine must take a much longer course of preparation than ever before. Medicine is, indeed, a hard taskmaster and should be — the health and the lives of our beloved ones must be placed in the hands of these men. So that from their point of view and from ours they cannot be too thoroughly educated and trained in the care of this mysterious body of ours.

All this is preliminary to saying that it is to be hoped that our government will permit these young men to complete their medical education, their internships, and their residencies so that they can adequately meet the future demands which will be made upon them by our civilian population as well as by our army.

There is another phase of this question which should be given careful thought by our government. In the last war the great need was for doctors at the front: base hospitals, doctors, nurses, and still more of all three, to meet the demand of immediate care of wounded soldiers. In the warring countries today that picture is, to a very large degree, changed. It's the civilian population who are being injured and who stand in need of surgical care. Of course, the airplane is responsible for this but it definitely fixes the need of providing adequate care for the men and women at home. In our preparations we must provide that care which is an additional reason for giving opportunity for adequate training of our younger doctors.

Nurses. All that has been said in this issue regarding doctors holds equally true in the field of nursing. For the past few years there has been an increasing scarcity of nurses. We have, on a number of occasions, spoken of the problem of securing a sufficient nursing personnel to give adequate service in the hospitals. With any appreciable number of these women entering Army or Red Cross service, the home situation will become just that much more acute. It would seem, therefore, that to those young women who wish to prepare themselves for a very real service, the opportunities must be offered them in our schools of nursing. Larger classes of qualified students should be the aim of every approved hospital.

Other Employees. The care of the sick in war time is just as essential as in peace time and our efforts must be increased to meet the added demands. Hospitals must continue their great humanitarian service. And so another great opportunity is opened to all those men and women whose services cannot be utilized by the government to do their part in filling the gaps made in hospital organizations by war demands.

Nursing aids, social service aids, clerical aids, helpers in every department of the hospital! There will be employees needed for every service and certainly our institutions will welcome as employees all those who want to help.

Then, too, the hospitals must be prepared to give training to those persons capable of going into various services — laboratories, x-ray and other types of technical work.

* * * *

THE HOSPITAL STANDARDIZATION CONFERENCE

Doctor Phemister's report on Graduate Training in Surgery clearly indicated a comparatively rapid trend toward higher standards in this field of medicine. It is evident that the time is not far distant when hospitals will limit surgical privileges to those practitioners who have been certified as competent in their respective fields.

The address by Father Schwitalla warned us that we must be alert to meet the changing conditions in hospital support, particularly support from Federal funds.

National preparedness was discussed from many angles and by many speakers. One concrete recommendation, however, was that hospitals should make every effort to have internes and residents exempted until such time as they had finished their training.

It was pointed out that so far in this war the bulk of medical service has been required for the civilian population and that we too must make our preparations with that thought in mind.

It was further stated that, with the higher standard being sought for the practice of medicine, interns and residents must be given the opportunity of perfecting themselves if they are to adequately serve their patients in the future.

There was some very excellent discussion regarding convalescent care of various types of patients.

We could well be proud of our record librarians. They held a number of meetings and were deeply interested in divising methods for improving their departments.

Our friend (?), MacEachern, had meetings daily from 7:45 A.M. until 10:30 at night with an hour out for lunch and a little longer for dinner.

* * * *

ARMISTICE DAY

At Grace Gospital, New Haven, this day was celebrated with a flag raising. At 9 A.M. a Boy Scout sounded *Retreat* as the old flag was lowered and then the bugler sounded *To the Colors* as the new flag was raised.

The thing of most importance connected with this ceremony was the fact that the new flag, 8 x 12 made of wool, was purchased with contributions made by our employees. It was just another evidence of the loyal interest of this organization.

* * * *

FROM AN ADDRESS BY ABRAHAM OSEROFF, RETIRING PRESIDENT OF PENNSYLVANIA HOSPITAL ASSOCIATION

At no time in the history of our institutions did we experience a period when careful inventory of the facts was more important. Communities today are more alert to the service which they may expect or demand of their hospitals. Trustees and hospital management in whom is vested final authority within the hospital, but who in essence act or should act as the voice of the community for determination of proper methods for meeting community needs, must realize that however much we have accomplished to the present, a great deal remains to be done to bring hospital service to its highest peak of efficiency and within the sphere of attainment of all those who may need such service.

No negative policy can fit the need.

At no time was it more important that there be united action on an understanding and cooperative basis than today. With full realization that different types of hospitals and in different localities necessarily have varying interests, it still must be stressed as a basic essential that all hospitals find some way of fitting into a cohesive program in order to meet the hospital and health needs of our communities. For many of the problems faced today there cannot be even an attempt at solution through any individual institution — large or small.

Hospital financing, which today is a wholly different job than it was even a decade ago because of our vastly different tax structure, because of shrinkage of income on endowments, because of shrinkage of the sources of large private giving, cannot be undertaken with any degree of effectiveness by a single hospital. The causes which have created our financing problem in voluntary hospitals in this state and throughout the country are as deep as the basic influences guiding the change in the general economic structure of the nation.

Our realization that hospital employees are not a segregated group, but members of the same community, having the same interests — publicly, socially, and as families — as any other group, wherever employed, means a considerable change in employee relationship. It is a happy incident that amendment to the Social Security Act bringing hospital employees within its benefits seems on the way to enactment by Congress. Our employees never should have been left outside the benefits of social security coverage.

Few people realize how infinitely more complex is the work of the doctor and the hospital than ordinary business with which hospital management is so often confused. We deal not with wood and brick and steel. We do not transfer merchandise across the counter at a price and in the hope of profit. Our daily task revolves around human life itself. Physical ills we minister to, but the heart and mind and soul in their hidden reactions which cannot be dissociated from physical ills, color necessarily the work of the doctor, nurse and, hospital employee. The aim here is not profit in dollars, but profit in satisfaction through effectiveness of the service which can be rendered to the adult or to the child who is the patient, and, in the aggregate, to all who come within the sphere of influence of our hospitals in their reflex upon community well-being.

Letters to the Editor

October 21, 1940

Dear Editor:

I am sure your readers will be interested in the experience of S. H. Liljestrand, M.D., missionary of the Methodist Church in Chengtu, West China, along the Burma Road, and perhaps one or more readers may be interested in giving aid to his hospital. Dr. Liljestrand (M.D., Syracuse, 1915) is a native of Jordan, N.Y., and has been in China since 1916.

The Women's Hospital, connected with West China Union University, Chengtu, was completely destroyed in a fire which followed a Japanese air-raid in August.

"The fire which destroyed the Women's Hospital destroyed all of my cystoscopic and electrotherapeutic apparatus and the accessories of a general gynecological clinic", writes Dr. Liljestrand. "Fortunately I had loaned a cystoscope to the Men's Hospital a block away. Also, the radium was saved, being in a patient that night. The patient was ambulatory. She went to a China hotel because of the fire. In the morning her honorable husband informed us of her whereabouts and the radium was recovered! I still have only fifty milligrams — but that is a mighty help.

"I lost a diathermy machine; an ultra-violet lamp, large size; three adult-size cystoscopes; one infant's and one children's cystoscope galvanic electric apparatus.

"The fire also destroyed our medical periodicals — including those on urology, surgery, gynecology, and obstetrics. . . . . .

"I would be very glad if we could get second-hand apparatus, and used copies of magazines. There continues to be a great demand for our service in this war-torn section of China."

If any of your readers are interested in assisting Dr. Liljestrand with used but good conditional material, will they please communicate with the Medical Department, Board of Foreign Missions, Methodist Church, 150 Fifth Avenue, New York City.

I trust you will be able to call this matter to your readers' attention. It will be greatly appreciated.

Sincerely yours,
William W. Reid
Board of Foreign Missions of the
Methodist Episcopal Church,
150 *Fifth Ave., New York, N.Y.*

The Doctor's Office

John C. Shull, M.D., announces the opening of his office at 735 Farmington Avenue, West Hartford, practice limited to Gynecology and Obstetrics.

William M. Wiepert, M.D., and Lucille R. Farquhar, M.D., announce the opening of their office for the practice of Medicine and Pediatrics at Avon.

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

(SEE PAGE 2)

Medical Preparedness

PHYSICAL STANDARDS IN THE SELECTIVE SERVICE

Volume Six of the Selective Service Regulations outlines the physical standards and administrative procedure for the physical examinations under the Selective Service Law. Some of the important provisions in these regulations are given below for general information. All physicians serving with Advisory Boards or as examiners to local Boards have been provided with copies of Volume Six.

Objective of the Physical Examination (602).

The objective is to procure men who are physically fit for the rigors of general service. The registrant must be able to see well; have comparatively good hearing; have a heart able to withstand the stress of physical exertion; be intelligent enough to understand and execute military maneuvers, obey commands, and protect himself; and be able to transport himself by walking as the exigencies of military life may demand. Examining physicians will accordingly so construe these standards that the objective stated above may be realized.

Scope of the Examination (606).

In all cases the examining physician shall make a complete examination of the registrant, and record all minor defects as well as disqualifying defects. Medical Advisory Boards, or a member or members thereof, shall make such examination as is necessary to determine the matters for which the registrant has been referred, and shall make an appropriate report . . . When in doubt about these or other conditions, the examining physician of the local board shall request reference to a medical advisory board for examination.

Where the Examination may be held (607).

The conduct of the examination in the rooms of the local board is not mandatory; the examination may be held in the office of the examining physician.

Examining teams (608).

In municipalities where several local boards and their examining physicians are located within reasonable distance, the formation of an examining group or groups for the conduct of physical examinations is authorized and encouraged.

Reportable Diseases (614).

Examining physicians, additional examining physicians, and members of Medical Advisory Boards shall report to the appropriate civil authority, in the required manner and form, those diseases which are found during physical examination made under these regulations, and which have been declared to be reportable by law.

The Examiner's Family (134).

No examining physician shall examine for a board any registrant who is a first cousin, or closer relation, either by blood or marriage, or who is an employe or employer, or stands in the relation of superior or subordinate in connection with any employment, or is a partner or close business associate, of the physician. The board shall request the Governor to recommend the appointment of another physician for such a registrant, or shall use the examining physician of another board.

Consultation and Advice (338).

When in doubt about the registrant's physical qualifications, the examining physician shall request the local board to send the registrant to a medical advisory board.

Malingering (340).

(a) If a registrant claims an ailment or defect which the local board cannot detect or if the local board believes him to be feigning the ailment or defect, it shall attach a statement of the facts and its opinion to both copies of Form 200. (b) If the local board believes that a registrant's disqualifying physical defects are self-inflicted or purposely caused to avoid military service the board shall immediately prepare in duplicate a full statement of the facts and the board's recommendations.

Equipment and Special Examinations (528)

(a) The Chairman of each local board is authorized to request the State procurement officer for selective service to furnish such supplies as may be required by the examining physician of such board. (c) The chairman of each local board may authorize such special examinations and laboratory tests as he deems necessary and shall cause to be forwarded to the State procurement officer for payment the bill for such examinations and tests after affixing his approval.

Confidential Records (165).

(a) All records pertaining to the physical condition of the registrant, and all answers on the questionnaire under the subject "Dependency" (except the names and addresses of claimed dependents), and to the questions on previous military service, shall be confidential and shall not be disclosed without the consent of the registrant, (with exceptions). The fact that a claim for deferment has been made on grounds of dependency or physical unfitness, and the classification of the registrant, are not confidential.

Venereal Disease. Telegraphic instructions.

"No man with acute or chronic venereal disease will be accepted for military service. For administrative purposes Selective Service will consider two positive serological tests performed within three months to be evidence of latent syphilis and to be cause for rejection."

* * * *

DOCTOR GEORGE M. SMITH RECEIVES IMPORTANT PREPAREDNESS ASSIGNMENT

Doctor George M. Smith of Pine Orchard, the Chairman on Medical Preparedness for The Connecticut State Medical Society, has lately been named to the Subcommittee on Industrial Medicine of the Health and Medical Committee of the Council on Medical Defense. Serving with Doctor Smith on this important comittee are: Chairman, Clarence D. Selby, Medical Consultant of the General Motors Corporation; Professor Philip Drinker of the Harvard School of Public Health; Lloyd Noland, Chief Surgeon, the Tennessee Coal, Iron and Railroad Company; Mr. William P. Yant of the Mine Safety Appliance Company; A. J. Lanza of the Metropolitan Life Insurance Company; and E. C. Holmblad of Chicago. Doctor Smith has for many years been the Medical Consultant of the Scoville Manufacturing Company, Waterbury.

The Subcommittee on Industrial Medicine is one of six such committees announced by Doctor Irvin Abel, Chairman of the Health and Medical Committee of the Council on Medical Defense. The other subcommittees are: Medical Education, Hospitals, Dentistry, Nursing, and Negro Health. "In announcing these subcommittees, "*The Journal of the American Medical Association* for Nov. 2 reports, "Doctor Abel stated that these subcommittees would assist the Defense Council's Medical Committee in coordinating health and medical activities and in 'mobilizing the medical resources of the nation for national defense.'

"The general committee has already had two meetings and, in addition to setting up its various subcommittees, has considered the need for developing research projects dealing with special problems of military medicine and hygiene. Examples of such special problems are finding better methods of treatment of war wounds, exploring the most modern usages of recently discovered chemicals in the treatment and prevention of disease, problems of aviation medicine, and the most effective measures for the control of the venereal diseases.

"The committee is also concerned with the necessity for providing health services in areas surrounding military camps and cantonments and with the health and medical problems resulting from greatly expanded industrial development in certain regions of the country.

"The committee hopes to find ways and means of providing adequate medical facilities and personnel, including hospitals, physicians and surgeons, dentists and nurses for the armed forces of the nation without the serious disruption of these essential services on the home front. It is enlisting the services and coordinating the efforts of both governmental and private agencies in building up the health and medical facilities of the nation as part of the present peacetime mobilization."

* * * *

ONE THIRD OF ARMY APPLICANTS REJECTED FOR PHYSICAL REASONS

Of 6,743 applicants for enlistment in the Regular Army during June, July and August 1940 in the Southern New York District of the Second Corps Area, which includes New York City proper, 2,195 or more than 32.5 per cent were rejected for failure to meet the Army's physical requirements, George E. Leone, M.D., captain of the Medical Corps of the U. S. Army and medical inspector for recruiting of the Second Corps Area, New York, reports in *The Journal of the American Medical Association* for Oct. 12.

The major causes for rejection of these men, who had the other required Army qualifications, were teeth, eyes, height and weight (stature), feet and ears in that respective order, Captain Leone says.

The report is of value, he says, in giving medical examiners a clue as to what to look for particularly in the examination of applicants. "It is also hoped that some preventive and remediable measures may be instituted for the better preservation of the health of the youth of our nation," he points out.

"It must be remembered that the applicants in the group covered by the present report were volunteers — young men who believed they were physically fit to fight for the defense of their country." Certain diseases rarely encountered in such men might be found much more frequently among those required to report for service, he observes.

* * * *

TWO POSITIVE SYPHILIS TESTS WILL BE SELECTIVE SERVICE BAR

Two positive serologic tests for syphilis performed within three months will be considered evidence of latent syphilis and to be cause for rejection by Selective Service boards, *The Journal of the American Medical Association* has been advised by the Director of Selective Service, it reports in its Nov. 9 issue.

* * * *

INDUSTRIAL HAZARDS TO THE EYES

Expansion and speed-up of industrial production, made necessary by national defense plans, increase the hazards which may result in eye injuries and other types of accidents, it is pointed out by Mrs. Eleanor Brown Merrill, Executive Director of the National Society for the Prevention of Blindness, in announcing the appointment of an Industrial Advisory Committee, headed by Dr. Leonard Greenburg, Executive Director of the Division of Industrial Hygiene, New York State Department of Labor.

"Industrial eye diseases and eye accidents constitute one of the principal causes of blindness in America," Mrs. Merrill explained. "Although industry has made much progress in the campaign to protect the sight of workmen, new processes have created additional hazards. The national defense program, necessitating the employment of large numbers of men in new jobs — working in strange surroundings, perhaps in plants operating on a twenty-four basis — makes for an inevitable increase in the danger of accidents. Some of these new employees are untrained, or use operations that are unfamiliar.

"To deal with these problems and other matters concerning the protection of workmen from eye diseases and eye accidents, the National Society for the Prevention of Blindness decided to appoint an industrial advisory committee of outstanding authorities. The Society also has under way an exhaustive study of the entire problem of eye hazards in industry, and will make this public shortly."

* * * *

Tuberculosis, during and after the World War, has cost approximately $960,000,000 to date in compensation, vocational training, insurance and hospitalization. The moist rale, which was the criterion of fitness for the World War, is shown by experience, much of which has accumulated since that time, to be much less reliable than radiography in situations analogous to the examination of recruits. A huge amount of compensation has been paid out to men manifestly tuberculous at the time they were sent to camp who should have been rejected by the local draft boards, but were not.

A normal chest roentgenogram should be the criterion of acceptance in a future mobilization, including the draft for training, and it should be made and reported before the recruit has spent a night away from his own roof to obviate a repetition of the claims for aggravation of pre-existing tuberculosis which occurred during and after the World War. Ramsay Spillman, M.D., *Jour. Amer. Med. Assn., Oct.* 19, 1940.

FROM WESTCHESTER (N. Y.) AND PHILADELPHIA

The Medical Preparedness Committee of the Medical Society of the County of Westchester (N. Y.) reports that it is investigating plans for the protection of the incomes and practices of physicians called away from home for military service. The Committee is also working out plans for the maintenance of the membership in the County and State Societies of all men who are called away from home on military service.

The Board of Directors of the Philadelphia County Medical Society, in order to protect physicians who serve in the armed forces, has presented a plan for arrangements with physicians who take over the practice of those in service. First, it was recommended that the physician leaving his practice send cards to his patients stating who is to be in charge of his practice and register the arrangement with the county medical society. The locum tenens should agree to place all funds collected from patients thus turned over to him in a separate fund, to deduct the amount necessary to cover overhead and divide the remaining funds 50-50, and when the practitioner returns from military service to refer all his patients back to him.

* * * *

LONDON HOSPITALS CARRY ON SERVICES IN SPITE OF BOMBARDMENT

"The indiscriminate bombing of London has involved several hospitals, as many as three in one night," the regular London, England, correspondent of *The Journal of the American Medical Association* reports in the Oct. 26 issue. "In one case a high explosive went straight through the glass dome, crashed through a five story staircase and landed on the ground floor. Fortunately there was only one casualty, a doctor who was working in his office. The desk in front of him disappeared and he remained perched on his chair near the wall with a 50 foot chasm in front of him. Despite a badly cut head he was rescued by firemen alive. When nurses opened the doors of the various wards they found a yawning abyss in front of them. The staff worked heroically getting 100 patients to the ground floor by an emergency method. Some were slid down a wooden ramp which had been put up only the day before. Others were carried down fire escapes. Among the patients were thirty casualties from previous air raids. Two more bombs fell on the works department. Though stricken, the hospital carried on. While the patients were being evacuated, four air raid casualties from the area were dealt with and one serious operation was performed.

"In another attack doctors and defense workers carried on in the street while bombs were falling and a direct hit occurred on a nearby shelter containing 1,000 people. The injured were attended to in the street in the glare of the flame-lit sky and transferred to waiting ambulances while the bombers droned above.

"The largest of the hospitals, the London, has been bombed several times. The two hundredth anniversary of its foundation has just been passed. The king sent a message of congratulation in which he expressed admiration for the way in which the medical and nursing staffs are carrying on in spite of the repeated bombing.

"The hospitals are working under new conditions. Their ordinary patients have been removed to safer localities and they are being used for the treatment of air-raid casualties, which are dealt with in the first instance by an ambulance service organized for the purpose before the outbreak of war. Great demands have been made on this service as well as on the auxiliary fire department organized to cooperate with the regular fire department in dealing with the fires produced by incendiary bombs. The experiences of the last few weeks have shown the soundness of these services, which consist of volunteers trained for the purpose. They have shown an excellent spirit and worked with great devotion. They have suffered air-raid casualties, of which some have been fatal. The ambulance service has had to transport many air-raid casualties to the hospital and in spite of the blackout the average time taken to reach a casualty has been only seven minutes from the receipt of the call. Casualties among the personnel have been numerous. The London County Council is providing for persons rendered homeless by air raid rest centers, bedding and hot meals."

New England Conference on Tomorrow's Children

CAROLINE RUUTZ-REES, **Greenwich, Conn.**

The first New England Conference on Tomorrow's Children was held at Harvard University during July 24, 25 and 26, 1940. The program consisted of an opening session presenting the theme of the Conference, panel discussions for different groups on two mornings, and lectures by two notable speakers each evening.

The session once opened by Director Kirtley F. Mather of the Harvard Summer School, Professor H. W. Holmes, Dean of the Graduate School of Education, addressed the Conference on "The Teaching in Public Schools of Home Membership". He emphasized that this should be taught as citizenship is taught, i.e., the intellectual ordering, as of an important subject, of youth's approach to family life. Professor Holmes believes that traditional education with its constraint of hours and text books must be relinquished; for it fails to prepare the large body of public school pupils for life. He left one wondering whether traditional education, as referred to by innovators, whatever its real faults, is not coming to play the part of the innocent man of straw.

The second speaker, the Industrial-Agricultural Commissioner of Vermont, Joseph Winterbotham, dwelt upon the expansive opportunities for tomorrow's children in new products as substitutes for New England's traditional industries; potatoes grown for starch, instead of whale oil; in place of cotton and wool fabrics, nylon and rayon; soy beans for scores of uses and—supplementing the New England metal trades—the new plastics, among them acelac, to be manufactured from New England's abounding milk supply. Even hats, a present industry of the region, might, he remarked, consist 50% of milk! But, with whatever opportunity, the future growth of industry depends upon good living conditions. The speaker referred in passing to interests which now stand in the way of slum clearance, means (Federal) for this being nevertheless already available.

Upon this prophecy and warning followed the speech of Professor Zimmerman of the Department of Sociology at Harvard. He ran over the problems to be considered. How many children will there be in the next generation? What their parent's background? How sufficient their food and medical treatment? What their social problems? What equipment, what resources are we leaving to our children, in view of the aims of World Powers? The generous birth rate is concentrated in a very few regions among very few classes, — not including the present ruling classes which will be engulfed and will decay leaving less capable generations in command. The American population is, in fact, barely reproducing itself, and its decrease has spread from the most well-to-do to farmers and workers. At present population is being maintained by the poor farmers. The speaker pointed out the good and bad sides of of birth-control. With few children there is better physical care. The mere 5% who produce the most children are not even families on relief, who have the food-card system; but underfed people who are not on relief. As a result, the new generation will suffer from serious dietary deficiency. The prospect is not rosy if the trends of the present generation continue. If we are unwilling to solve the problem of diet, i.e., proper feeding of the very poorest, we shall leave an inheritance of hate and class trouble. It is for the people of America to find the solution of the problems that loom ahead.

Panel discussions were held each of the three afternoons, one afternoon being devoted to each of three subjects, the Underdeveloped Family, the Overdeveloped Family, and the Balanced Family. With the utmost clarity Doctor John Rock of the Free Hospital for Women, Brookline, set forth the involuntary and voluntary causes of infertility, manifest or occult, in male or female. Doctor Rock closed with the dictum that diversion of a woman's interest from reproduction and the care of children deters her husband from fatherhood. The hope of the future includes less feministic education for both sexes. Perhaps this conclusion to a most brilliant address had struck a less jarring note if that note had not of late years sounded so clearly across the water.

Doctor Merrill Moore, Associate in Psychiatry at Harvard Medical School, pointed out that in the lower income brackets to fail of a large family is a hazard for old age. Professor L. H. Mowrer of the Department of Psychology, Yale Institute of Human Relations, added that, in general, where there is opportunity to earn, working families produce more children.

Clyde V. Kiser of the Millbank Memorial Fund, himself in favor of the judicious use of contraception, uttered a warning that a thousand babies of today must be expected to raise less than a thousand themselves. The age structure of our population is changing, as evidenced by the 1940 census, with fewer under twenty and more over sixty five years.

Among the speakers the first evening was Frank Lorimer, Professor of Population Studies, American University, Washington, D.C. In his subject, "Future Building in Democracy", Doctor Lorimer pointed out the contrast between our crop surpluses with even greater possible production and the inadequate nourishment of the Nation's children. The economic penalties in large families are accelerating the trend towards population decrease. He believes that the Nation must accept the responsibility for providing means to make possible an equality of educational opportunity and health facilities for its children. In the United States the present existing approximate balance between fertility and mortality will give way to a trend towards population decrease as the practice of family limitation reaches more isolated groups. Meanwhile contraceptives are less available to the poor than to the middle and upper classes. Strenuous efforts must be made to break the vicious circle between cultural retarding, excessive fertility, population pressure and poverty. The real issue is not whether social controls shall or shall not be extended, but whether they shall be ruthlessly administered towards barbaric objectives or democratically developed to serve humanitarian goals, as in the Swedish program.

Among the Conference subjects was a discussion of the "Teaching of Home and Family Living in the Secondary School." This was led by Conrad Taeuber of the Department of Agriculture, Washington, D.C., and Guy I. Burch, Director of the Popular References Bureau, Washington, D. C. In this discussion there were brought out the wide differences in fertility between the various regions of the United States. This results in two thirds of the Nation's children growing up in the least fortunate third of our population. (See Journal, Vol. IV. No. 9, page 550, Book Review of "Tomorrow's Children").

In the Round Table discussion on Sex Education, led by J. L. Kaukonen, Assistant Health Education Specialist of the U. S. Public Health Service, it was emphasized that sex education is still a controversial subject in spite of the 1936 campaign against syphilis and gonorrhea.

In the Panel discussion on "The Overdeveloped Family," Doctor Woodbridge E. Morris, Medical Director of the Birth Control Federation of America, put the case for contraception. Stating that the modern woman will find a way of planning a family, Doctor Morris claimed that Society should show her the safest way. The proper spacing of children is good for mother and offspring and a chain of uninterrupted children is likely to be less gifted, less healthy, less long lived than if properly spaced. In presenting the Catholic point of view the Reverend Eric Mackenzie emphasized that due preparation for marriage on a proper income, rather than contraception, is the answer to the family problem.

Professor Earnest A. Hooten of the Department of Anthropology, Harvard University, in one of the evening lectures sounded not too hopeful a note. Because of our humanitarianism, the world is crowded with those who are too dumb or too old to work. Democracy has pampered the unfit. Their activities must be restricted. If man is to be reclaimed he must make the effort to understand the laws of heredity. Religion is a necessary element in social improvement; so also is education; it trains the mind to be able to utilize its capacity. Education must get rid of its neoplastic growths, the church of ecclesiastical bigots, democratic government of demagogues, and the Nation, by genetics, of the unfit, and by euthanasia of the hopelessly diseased.

At this invigorating Conference, the humanitarian per se was not represented. An impartial listener might have found food for thought in the approximation — exception possibly made for Professor Hooten — of the scientific discussion of population and genetics to the point of view of the absent humanitarian. Incentives may be different, but when the question arises, "what is to be done"? scientist and humanitarian are found, rather unexpectedly, to be seeing eye to eye.

-The- General Practitioner's Forum

Preoperative care is well within the province of the family doctor and should be his definite responsibility. All things being equal, a calm, assured and well prepared patient has the best chance of surviving a major operation. The procedure is not difficult. The principles involved are simply those of rallying all the protective and recuperative forces in the body. It is obvious then that the family doctor, by reason of the confidence the patient rests in him, should be the man best fitted for the job. First in importance is a tactful discussion of the operation with the patient. Fear is a destructive force and it must be controlled. One's own good judgment and estimate of the patient's emotional stability should guide the scope of the discussion. Next in importance is the condition of the blood. This should be brought to peak efficiency by the administration of suitable medications or by repeated transfusions where necessary. It should be typed and cross-matched with available donors just in case of emergency. It is also advisable to give calcium to aid clotting. A diet as tolerated should be liberal in proteins, carbohydrates and vitamins, especially vitamin C which seems to bear some relationship to wound healing. Fruit flavored hard candies are rich in dextrose and are recommended additions to the diet. The fluid intake should be ample for proper elimination. In the diabetic it is advisable to increase the diet and insulin in order to promote glycogen storage. Adequate rest must be maintained and where necessary by the use of mild sedatives. It may be advisable to prescribe a mid afternoon rest period. In the special case of operations on the lower intestinal tract many surgeons recommend a course of immunizing doses of vaccine containing B. coli. The final step is to have the patient enter the hospital a few days before the date set for the operation. This period is utilized by the surgeon for final preparations and by the patient for adjustments to the routine of the hospital, and especially in the use of the bedpan and urinal.

* * * *

At the June session of the American Medical Association, Section on Obstetrics and Gynecology, DeLee and others condensed the indiscriminate use of posterior pituitary extracts. Admittedly a powerful and valuable drug in its proper sphere, there is no place for it in normal labor due to the high incidence of maternal and fetal injuries. The correct indications for its use are outlined. In all cases the initial dose is small — from 0.05cc to 0.2cc. After the expulsion of the placenta 0.5cc may be used. During pregnancy: when abortion is in progress, 0.1cc hourly until the uterus is empty. In incomplete abortion before curettage, 0.5cc will stiffen the uterus and afford a harder surface to the curette. Labor: properly safeguarded it may be used to induce labor. However, it must not be used in placenta praevia. Initial dose 0.05cc followed by 0.1cc every twenty minutes until some effect is seen. The total amount used at one trial is never more than 1.0cc. During labor itself, except for uterine inertia and premature separation of the placenta, there is no need for it. In the third stage opinion is divided. His own preference is to use it after the placenta is out. In special instances such as following operative delivery or when uterine atony is feared he uses it as soon as the baby is delivered. During the puerperium it is not needed and has been replaced by an ergot preparation.

(Concluded on Page 773)

Our Neighbors

MAINE

Doctor Alan Craig and his staff at the Eastern Maine General Hospital, Bangor, carried out an excellent program for the Fall Clinical Session of the Maine Medical Society, according to all reports. The total registration was 162, with over 100 attending the dinner. The speaker of the evening was Doctor A. Nowell Creadick of New Haven whose address provoked considerable discussion by many of the members present at the dinner. Thus does Connecticut contribute to medical education in neighboring states.

* * * *

NEW JERSEY

The Medical Society of New Jersey has authorized an award of $100 for the best essay on an original medical subject, submitted accordign to certain rules. The Medical Society of New Jersey, celebrating its 175th anniversary, will be addressed on March 24, 1941, by Doctor Frank H. Lahey, President-elect of the American Medical Association, at a meeting in Asbury Park. Doctor Lahey will speak on "The Health of the Nation." This Society was founded on July 23, 1766, thus laying claim to being the oldest State Medical Society in the United States.

* * * *

NEW YORK

The Council Committee on Public Health and Education of the Medical Society of the State of New York has arranged a variety of courses and lectures as part of its postgraduate instruction program. Many of these activities are presented in cooperation with the State Department of Health. Individual speakers are available, also one day instruction sessions made up of clinics, demonstrations, and lectures. A special feature of this educational program is a new emphasis on plastic and reconstructive surgery as part of its medical preparedness program. A special lecture on pneumonia treatment including chemotherapy has been prepared and is available.

- NEWS -

from County Associations

Fairfield

The November meeting of the Stamford Medical Society heard a paper: "The Physician and the Compensation Laws" by Mr. E. T. Buckingham, Compensation Commissioner. With his background of long experience in this field, Mr. Buckingham gave an interesting and valuable exposition of his subject.

On November 12 the Bridgeport Medical Association was addressed on the subject: "Office procedures in Ear, Nose and Throat." The speaker was Doctor Clarence H. Smith, Surgeon and Chief of the Bronx Ear, Nose and Throat Hospital. The matter was well presented, with emphasis on the needs of men in general practice.

"Radiology for September 1940" contains an article by Leo Hymovich and Arnold Bachman of Stamford, entitled: "Traumatic Periostitis and Malacia of the Foot."

Voyle A. Paul of the surgical staff of the Stamford Hospital was elected a Fellow of the American College of Surgeons at its recent meeting in Chicago.

Donald R. MacLean, long identified with anesthesiology in Stamford and now retired from active practice, was made honorary member of the American Society of Anesthetists at the October meeting of the society in New York City.

* * * *

Hartford

The Hartford County Medical Association held its semi-annual meeting at the Masonic Temple in Manchester on October 22nd. Several of the members enjoyed golf at the Manchester Country Club in the afternoon. The cup donated by Doctor George Lundberg and awarded to the local town or city team with low gross score went to Simsbury represented by Doctor James E. Stretch. 110 attended the dinner which followed the business meeting. At this meeting it was voted to donate $100 to the National Physicians Committee. Doctors George M. Smith, Chairman of the State Committee on Medical Preparedness, and William B. Smith, Division of Aeronautics, State of Connecticut, outlined the medical defense program as it had developed to date. Following the dinner Dean Francis G. Blake of Yale University School of Medicine spoke on "Chemotherapy with Sulfapyridine and Sulfathiazole." Doctor A. Elmer Diskan of Manchester presented a report of a case of adrenal insufficiency.

The first meeting of the members of the various Selective Service Examining Boards and the Medical Advisory Board in this district was held at the Veterans' Home in Rocky Hill on November 7. Major William B. Smith, medical officer attached to the Selective Service Board in Connecticut, explained the details of operation of the registration act and the examination of registrants. Among other significant statements Major Smith said that approximately 270 physicians in Connecticut had been called upon for work in connection with the draft and of these all but four had accepted, three having good reasons for refusing.

The County Association mourns the loss of its member, J. Tyree Woodson of Hartford, who had worked among us for eighteen years. His death occurred at his home in West Hartford on Saturday, November 9. The sympathy of the members of the Association is extended to his wife and family.

On November 4 the Hartford Medical Society was greatly favored and benefited by an address on "Lung Abscess" by Doctor Richard Overholt of Boston. Doctor Overholt stressed the more universally accepted opinion of the necessity for early operation in lung abscess. His paper was accompanied by slides which very clearly demonstrated the pathology and described the manner of surgical approach in lung abscess.

A short while ago we had the Peripheral Venous System discussed by Doctor Mahorner of New Orleans. The Hartford Medical Society takes pleasure in announcing that on December 16 it will have as its guests Doctor E. V. Allen of the Mayo Clinic who will discuss the Peripheral Arterial System. This interesting subject merits a goodly attendance both because of the prominence of the speaker and the importance of the subject.

The Journal of the Maine Medical Association, November 1940, contains a paper on "Pentothal Sodium — Its Field of Usefulness" by Linus J. Miller, M.D., and Ralph M. Tovell, M.D., both members of the anesthesia department of the Hartford Hospital. The statistical tables included in the paper are compiled from records of cases at the Hartford Hospital in 1939.

* * * *

Litchfield

On November 12, Doctor W. B. Walker, Chief of the Medical Service of the Charlotte Hungerford Hospital, presented a paper on "Pneumonia" before the Graduate Nurses Club of Torrington.

Doctor Pauline C. Riendeau and Doctor Fernand N. Riendeau have recently opened offices at 30 Mason St. Doctor Pauline C. Riendeau is limiting her practice to medicine and gynecology according to a recent announcement.

At the monthly meeting of the Tumor Clinic of the Charlotte Hungerford Hospital held in the Staff Room on Nov. 6, cases were presented as follows:1. Bone Sarcoma by W. B. Walker. 2. Carcinoma of Breast by John F. Kilgus. 3. Malignant Ovarian Tumor by E. H. Wray, Jr. Doctors C. J. Bartlett and R. T. Ogden discussed the pathological and roentgenological aspects of these cases.

On evening of November 6, Colonel Harry L. Dale, M. C., U. S. A., addressed the bimonthly meeting of the Torrington Medical Society at the hospital. Colonel Dale outlined the organization of the Army Medical Corps since 1918. He explained the opportunities presented to all physicians regardless of age for service in the National Defense Program. The meeting ended in an enthusiastic and thoughtful round table discussion of the many problems presented by the speaker. Following the meeting refreshments were served.

* * * *

Middlesex

At Bengston-Wood Hall, Middlesex Hospital, on the evening of Oct. 14, Doctor Harry E. Stewart of New Haven gave a paper on "Practical Points on Physiotherapy."

On the evening of Nov. 11, at the same place, Doctor Joseph Beauchemin of the Connecticut State Hospital discussed "Parkinsonism and Pernicious Anemia," illustrating the talk with moving pictures.

At the weekly medical conference on Oct. 30, Doctor Harry S. Frank presented the subject of "Peritoneoscopy" and was able to demonstrate a case wherein there was some question as to the presence of an intra-uterine or extra-uterine pregnancy. With the use of the peritoneoscope the diagnosis was at once established.

Doctor G. M. Craig of Haddam and Middletown has recently returned from Chicago where he was inducted into fellowship in the American College of Surgeons. He was accompanied on his trip by Doctors Sweet and LaBella, the latter of whom has recently addressed physicians of the hospital on "The Proceedings at the Recent American College of Surgeons' Meeting."

* * * *

New Haven

The New Haven Medical Association mourns the loss of one of its members, Oliver Thomas Osborne, well known throughout the country for his pioneer work on tuberculosis. On November 14, Doctor Osborne would have attained the age of seventy-eight. During most of his medical career he served Yale Medical School and served it well.

The Weekly Roster and Medical Digest (Phila.), October 19, 1940, contains a paper on "Relation of Sex Hormones to Cancer" by W.U. Gardner, M.D., Department of Anatomy, Yale University School of Medicine. Doctor Gardner presented this paper before the Philadelphia County Medical Society in March of this year.

"The Treatment of Phenumococcal Pneumonia" is the subject of a paper appearing in the *New England Journal of Medicine* (October 24) and written by Doctor Francis G. Blake of New Haven. This paper was presented before the annual meeting of the Massachusetts Medical Society in Boston on May 21, 1940.

——☆☆——

GENERAL PRACTITIONER'S FORUM

(*Continued from Page* 770)

Enough material has collected to strongly indicate that local x-ray therapy will abort or inhibit the progress of thrombophlebitis and carbuncles. Where this type of therapy is not available, we have seen reports of good results following the use of sulfathiazole.

T. P. R., M.D.

THE ART OF MEDICINE

There are certain fundamentals governing the practice of medicine that should never be lost sight of but that should be taken into serious consideration by advocates of group practice when advertising their fad in grandiose style.

After all that is said to the contrary, the indisputable fact yet remains — medicine will always be an art as well as a science no matter what radical advances are made in the latter field. It necessarily will be so because there is an art in establishing prompt obedience to directions; in obtaining the wholehearted cooperation of a patient; in impairing and in getting adopted useful health information and instructions; in winning the confidence of frightened children; in understanding comprehensively the discouraging problems of the aged while sympathetically ministering to them; in entering strange homes and quickly achieving a commanding confidence among those present in one's ability to cope successfully with any emergency which has arisen. There is an art in comforting and assuaging the torturing pangs of a grief-torn soul; in being the tactful purveyor of sad, disastrous news to loved ones; in building up courage within those desperate individuals who, unfortunately, are forced by the exigencies of malignant disorders to go down into the depths of the valley of the shadow, their minds overwhelmed with the terrible fear that they may never return; and there is an art in smoothing the painful pathway of others who, without hope, are journeying gloomily, somberly down the dreary road which winds slowly but inevitably to that bourne from which no traveler returns.

The high-brow specialist may pass this off with a lofty condescending gesture and disparagingly term it just "selling a bedside manner." But it is more helpful to the sick than a jarring clash of personalities. It must be realized that medical science is an intricate highly complicated piece of mechanics, which has to be oiled by artful methods or it will squeak as discordantly as the rusty hinges on an antiquated mausoleum — especially so if it is manipulated by a bunch of obstreperous political bureaucrats.

From "Group Medicine Answered,"
Floyd Burrows, M.D., *N.Y. State J.M.*

News *from* Yale University School *of* Medicine

NEWS FROM THE YALE UNIVERSITY SCHOOL OF MEDICINE

The Yale Medical School and New Haven Hospital were hosts on November 1 to an Alumni Medical Convocation held for the purpose of acquainting the alumni representatives with the current status of medical teaching, research, and public health activities of this unit of the Yale graduate schools.

Luncheon and dinner addresses were made by President Seymour, acting dean of the medical school, Doctor Francis G. Blake, Doctor Milton Winternitz, and Mr. James A. Hamilton, director of the New Haven Hospital. The visitors were also conducted in small groups through the hospital and medical school where some of the teaching, clinical, and research facilities were exhibited by members of the several departments visited in the tour.

At the request of the National Research Council a Committee on Industrial Medicine and Hygiene has been appointed under the chairmanship of Professor Winternitz. It will work in close cooperation with the State Departments of Health and Labor and the Connecticut State Medical Society, as well as with such national bodies as the United States Public Health Service and Department of Labor, the Army and Navy, the National Research Council, and the National Academy of Sciences. The importance of the industrial activities of Connecticut and the probable expansion of those activities in an armament program demand from Yale a plan of protective health service such as the University alone can provide. The committee plans to organize at important industrial plants services for the protection of health and for security from special hazards, to inaugurate a teaching program designed for forty five students and covering three months, with special courses for nurses, engineers, chemists, and physicians, and to establish a division for research on problems arising from plant experience.

MEDICINE UNDER THE NEW FRENCH GOVERNMENT

According to the *New York Times,* a new medical order has been set up in Vichy, France, by the creation of a superior medical council attached to the Minister of the Interior with subordinate councils in each department of France. No one is permitted to practice medicine in France unless endorsed by one of the professional councils. For one year from the promulgation of the law these councils will function by government appointment, after which time they will be renewed by vote within the medical profession (Hitler willing). All medical organizations are abolished and their property is to be turned over to mutual benefit organizations to be established by the medical councils.

☆☆

NEW OFFICERS OF ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Dr. Ralph Irving Lloyd, Brooklyn, N.Y., was named president-elect of the American Academy of Ophthalmology and Otolaryngology at the annual meeting in Cleveland, October 6-10. Vice presidents elected were: Drs. Everett L. Goar, Houston, Texas; James M. Robb, Detroit, and Ralph O. Rychener, Memphis, Tenn. Dr. Frank R. Spencer, Boulder, Colo., will be president during the coming year.

Dr. William P. Wherry, Omaha, Nebr., was reelected executive secretary-treasurer and Dr. Secord H. Large, Cleveland, comptroller. The board of secretaries was reelected as follows: Drs. William L. Benedict, Rochester, Minn., for ophthalmology; John L. Myers, Kansas City, for otolaryngology; Erling W. Hansen, Minneapolis, for public relations; Dean M. Lierle, Iowa City, for instruction in otolaryngology, and Albert D. Ruedemann, Cleveland, for instruction in ophthalmology. Dr. Oliver E. Van Alyea, Chicago, was reelected director of the scientific exhibit.

The Academy sponsored the first Pan American Congress of Ophthalmology, which was organized on a permanent basis, with Dr. Harry S. Gradle, Chicago, as president. Tentative plans were made for a meeting of this congress in Montevideo, Uruguay, in 1943.

The place of the 1941 meeting of the Academy was not to be determined until later.

SPECIAL NOTICES

DECEMBER MEETING — ASSOCIATION OF CONNECTICUT TUMOR CLINICS

The nineteenth joint meeting of the Association of Connecticut Tumor Clinics will be held at the Middlesex Hospital, Middletown, in the Nurses' Training School Hall on Thursday, December 12, 1940 at 4 P. M. under the chairmanship of Doctor Carl C. Harvey.

The program will be as follows:

Carcinoma of the Breast — Carl C. Harvey
Carcinoma of the Gastro-Intestinal Tract — Louis O. LaBella
Carcinoma of the Uterus — G. M. Craig
Case Presentations:
Three Unusual Bone Tumors — Alfred N. Sweet

Dinner will be served at the Hospital after the meeting.

* * * *

POSTGRADUATE OBSTETRICS

The Department of Obstetrics and Gynecology of the University of Chicago and the Chicago Lying-in Hospital through the cooperation of the Children's Bureau, U. S. Department of Labor and the Illinois State Department of Public Health offers five postgraduate courses of four weeks each between January 6 and June 21. The beginning dates of each are: January 6, February 10, March 17, April 21, and May 26. All the members of the department and all services and units of the institution participate in the instruction. Only a limited number of postgraduate students are accepted for each period. A deposit of $25.00 is required, of which $10.00 is returned on completion of the course. All communications should be addressed to: Postgraduate Course, 5848 Drexel Avenue, Chicago, Illinois

* * * *

EXAMINATION—AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The written examination and review of case histories (Part I) for Group B candidates will be held in the various cities of the United States and Canada on Saturday, January 4, 1941, at 2:00 P.M. Formal notice of the place of examination will be sent each candidate several weeks in advance of the examination date. No candidate will be admitted to examination whose examination fee has not been paid at the Secretary's Office. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held in June 1941.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, from May 28 to June 1, 1941, immediately prior to the opening of the annual meeting of the American Medical Association.

Application for admission to Group A, (Part II) examinations must be on file in the Secretary's Office not later than March 15, 1941.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

The Board wishes to annouce a modification of the case record ruling (effective January 1, 1942) as it appears in the September 1940 issue of the Board booklet. This ruling should read: "It is preferable that the number of cases submitted should not be more than half (25) of the total number of fifty (50) cases required."

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* * * *

AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY

Over 600 dermatologists from all parts of the U. S. A. and Canada are expected to come here for the third annual meeting of the American Academy of Dermatology and Syphilology at the Palmer House, December 8, 9, 10, and 11. There will be over 60 lectures on the program from Monday, December 9 through Wednesday, December 11. Sessions will be in the form of symposia, special lectures in courses of one to four hours each; numerous luncheon round table discussions, and clinical presentations at the University of Illinois Medical school in Chicago.

Guest speakers include Dr. Cyrus C. Sturgis, Professor of Medicine, University of Michigan, speaking on "Diseases of the Blood and Blood Forming Organs — their relation to the skin and mucuous membranes" (Monday morning); Dr. William F. Petersen, Professor of Pathology, University of Illinois, speaking on "The Patient. His Skin and the Weather" (Wednesday afternoon) and Dr. Elmer L. Sevringhaus, Professor of Medicine, University of Wisconsin who speaks Tuesday afternoon on "Endocrines and their Relation to Dermatology." The annual banquet is scheduled for Tuesday evening.

Actual cases of rare dermatoses and of other important skin diseases will be presented at the University of Illinois medical school Monday afternoon, December 9, by a score of leading dermatologists from various parts of the country. These clinical presentations will be arranged so that visiting dermatologists and syphilologists can attend several different presentations during the afternoon. Discussion of rare dematoses follows the meeting and will be resumed in the Palmer House that evening.

Symposia and their leaders include: Symposium on Physiology and Chemistry of the Skin, Dr. Donald M. Pillsbury; Symposium on Pharmaceutical Therapeutics, Dr. Otto H. Foerster. (Both to be held on Tuesday). Symposium on Allergy, Dr. Samuel M. Peck, and Symposium on Syphilis, Dr. Udo J. Wile, to be held on Wednesday. There will also be special courses in histopathology, mycology and x-ray and radium-therapy.

• OBITUARY •

JOHN FRANCIS LYNCH, M.D.

1898-1940

Doctor John Francis Lynch died of coronary artery heart disease at his home, September 27th, 1940. His age was 41.

Born in Norwich, Connecticut, the son of Timothy and Mary Driscoll Lynch, he received his early education in the public schools and the Norwich Free Academy. His education was continued at Yale University where he was an active member of the University track team. He was graduated from Yale College with the degree of Bachelor of Arts with the class of 1921. Continuing his professional education at the Yale School of Medicine he was graduated with the degree of Doctor of Medicine in the class of 1924.

Following his graduation from medical school he served his internship at Saint Francis Hospital, Hartford. This was the beginning of his association with this institution which continued without interruption until his death. At Saint Francis his unusual talents were soon recognized and his advancement in the department of surgery was rapid.

John Lynch was a man not cast in the ordinary mold. Endowed with an alert mind, deft surgical hands and an abiding interest in the art of medicine, he combined these attributes to the end that he should become a better surgeon. During the year 1935 because of ill health he was forced to give up his work. In 1939 with courage matched only by his love of surgery he took up his work knowing at this time that his heart ailment could have but one outcome and that his term of years was limited.

He was a brave and gallant man and a good doctor.

He was a member of the Hartford Medical Society, the Hartford County Medical Association, the Connecticut State Medical Society, and a Fellow of the American College of Surgeons.

He is survived by his parents, his wife and three minor children.

Edward J. Whalen, M.D.

LEO WILSON, M.D.

1903-1940

The death of Doctor Leo Wilson of Stamford, Connecticut, on October 13, 1940, brought deep sorrow to his many friends, patients, and medical associates. The end came as a shock, as his condition seemed to be greatly improved since the spring and he had apparently recovered from a prolonged illness and operation performed in May of this year. He felt very well throughout the summer, resuming his practice in August. In September he accepted his service on the surgical staff, and was operating on a ward service patient on October eleventh when he was seized with his fatal illness. Early on the morning of the thirteenth he lapsed into a coma and died at noon.

Leo Earl Wilson, son of Thomas and Mary Gould Wilson, was born in Fitchburg, Massachusetts, July 13, 1903. He received his education in the schools of that city and was graduated from the Fitchburg High School. He attended a preparatory school in Baltimore, Maryland, intending to enter the Naval Academy to which he had an appointment, but changed his mind and decided to study medicine. He entered the University of Vermont where he pursued the pre-medical and medical courses and received the degree of Doctor of Medicine from that institution in 1928. While in college he was a member of Nu Sigma Nu fraternity and of Cap & Skull, honorary medical society. He interned at the Bishop de Goesbriand Hospital, Burlington, Vermont, and the Stamford Hospital, Stamford, Connecticut, and in July, 1929 began practice in Stamford, where he had since followed his profession.

Leo Wilson was an excellent student with a keen mind that grasped subject matter with a minimum of effort. He had a pleasant and commanding personality and a well developed sense of humor. His cheerful presence will be missed by all at the hospital. The loss to his friends and patients will be great.

He was a member and at one time secretary of the Stamford Medical Society, a member of the Fairfield County Medical Association and of the Connecticut State Medical Society, and was a Fourth Degree member of the Knights of Columbus. He was on the surgical staff at the Stamford Hospital and was never happier than when on ward service.

His funeral was held at St. John's Roman Catholic Church at ten o'clock on October sixteenth. It was largely attended by his host of friends and former patients. The Medical Society of Stamford attended in a body, and there was a large representation of nurses, local government officials, and members of the Knights of Columbus. Interment was in St. John's Cemetery, Springdale, Conn.

Doctor Wilson leaves his wife, Anne McGronen Wilson; a son, Leo Gould Wilson; a sister, Mrs. Katheryne Cyr; and three brothers, Jesse, Thomas and George Wilson.

F. W. McFarland, M.D.
F. M. Bannon, M.D.

☆☆

MEDICAL EDUCATION CONGRESS DATE SET

The Thirty-Seventh Annual Congress on Medical Education and Licensure, conducted under the auspices of the Council on Medical Education and Hospitals of the American Medical Association, will be held at the Palmer House, Chicago, Feb. 17 and 18, *The Journal* of the Association announces in its Nov. 9 issue. During the Congress special consideration will be given to the relationship of the medical profession to national defense.

☆☆

NEW ENGLAND PROCTOLOGIC SOCIETY

The semi annual meeting of the New England Proctologic Society was held in Hartford on October 25th. The program included papers on "Technical Problems of Cancer of the Rectum" by Doctor Thacher W. Worthen, "Proctology as Practiced in an Orthopedic Hospital" by Doctor Harry Goldman of New York and motion pictures of the Battle of France presented by Doctor Andrew Taylor. Doctor Percy Brooks of Worcester was elected secretary of the society. The next meeting will be held in Providence, R.I.

CONNECTICUT TUBERCULOSIS ASSOCIATION

The Connecticut Tuberculosis Association held its first annual meeting on October 23 in Hartford. Doctor Ira V. Hiscock, Professor of Public Health, Yale University, was elected to succeed Doctor David R. Lyman as president. Doctor Charles C. Wilson of Hartford is the new vice president, and on the executive committee are Doctor Lyman of Cheshire and Doctor Joseph I. Linde of New Haven. Other physicians elected to the board of directors were Hugh B. Campbell, Norwich; Stanley H. Osborn, Hartford; Mario L. Palmieri, Middletown. Doctor Linde has been appointed by the president as chairman of a new committee to study the problem of rehabilitation of tuberculosis patients and to cooperate with the State Tuberculosis Commission and State Department of Education in the development of this phase of the tuberculosis program. Doctor Charles C. Wilson is also a member of this committee.

☆☆

THE UNIVERSITY OF CHICAGO CELEBRATES ITS FIFTIETH ANNIVERSARY

In 1941 the University of Chicago will celebrate the fiftieth anniversary of its foundation, the theme of the celebration being New Frontiers in Education and Research. In anticipation of this the Medical Schools of the University have issued a small volume of Announcements which contains an historical sketch of the University, another of Rush Medical College, a statement of requirements for admission, etc., and a detailed list of the courses available. It is the plan to issue invitations to "the academic festival" in due season, a cordial welcome being assured to all who shall honor the University with their company.

LISTEN TO A FOETAL HEARTBEAT

— through the new "two-channel" Davol Stethoscope Tube. This modern tube will improve your present stethoscope. Latex for long life, heavy wall for durability and to exclude extraneous sounds, with length and weight just right to make it easy to carry and easy to use. One tube; twin channels. No obligation — want to try one? Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

Only One in Ten Knows These Facts . . .

ABOUT EYES

Question:—*Whose advice should I first seek concerning my eyes?*

Answer:—Your Family Physician's.

Q.—*Who will the Family Physician recommend?*

A.—Your Family Physician will recommend an Eye Physician (medical doctor).

Q.—*Why an Eye Physician. (M.D.)?*

A.—Because the Eye Physician with his medical training knows the eye in its relation to the body. He can determine whether headaches, nervousness, etc., are due to eye trouble or have their origin elsewhere. When glasses are necessary he can prescribe them exactly for the corrective or relieving effect that is required.

Q.—*Who should fill my prescription for glasses?*

A.—Physicians recommend a Guild Optician — because the making and fitting of glasses calls for the skill of a master craftsman. When your glasses are made by a Guild Optician, you are sure that they will be exactly as your Eye Physician prescribed them.

ESTABLISHED 1890

THE Harvey & Lewis CO.

GUILDCRAFT OPTICIANS

With stores in . . .

Hartford
Springfield
Bridgeport
New Britain
New Haven
Worcester

GROUP

ACCIDENT AND HEALTH INSURANCE

Is Carried by the Majority of

CONNECTICUT PHYSICIANS

The Advantages of the Group Plan . . .

- Broader and more liberal coverage.
- Non-cancellable as to any individual member.
- Reasonable cost.

SOLD ONLY BY:

ARTHUR W. EADE

185 Church Street
NEW HAVEN, CONNECTICUT

• Quarto Notes •

TEXTBOOK OF MODERN DERMATOLOGY AND SYPHILOLOGY

by

S. William Becker, M.D., Associate Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago

871 pages 461 illustrations in text $12.00
32 full color plates
Philadelphia J. B. Lippincott Co. 1940

This is a modern book which emphasizes and stresses the entry of dermatology into its biologic era. Importance is placed upon disease processes rather than the static morphologic pictures. The text is exceedingly clear, well written and is in accordance with current thought in the field of dermatology and syphilology. The illustrations are nicely selected and beautifully reproduced. At the beginning of each chapter is a discussion under the heading "Orientation" which is "in the intimate language of the demonstrator to small groups of students" and adds considerable interest to the subject matter. Following each chapter is a short bibliography which has been thoroughly brought to date. The volume is not as comprehensive as the standard textbooks on dermatology as only those diseases commonly seen in the United States, Canada and Great Britain are discussed. This should prove more useful to the undergraduate medical student and the nondermatologic practitioner of medicine. A table presenting a cross-section of cutaneous lesions, both primary and secondary, and an outline which provides a brief index for ready reference on pigmentary disturbances should be of real help for the student. The chapter on deficiency diseases is rather brief but is supplemented with a sufficient and recent bibliography. In the chapter on drug eruptions, a list of cutaneous disorders caused by drugs, in addition to the listing of drugs followed by the diseases they produce, will be of special aid for the beginner. The chapter explaining the neurodermatoses is excellent.

The portion of the book pertaining to syphilology gives one "a comprehensive view of syphilis as an infectious disease including all information necessary for the practice of everyday syphilology." A valuable and complete bibliography of the Cooperative Clinical Group and of the committee on Evaluation of Serodiagnostic Tests for Syphilis is also present.

The volume can be enthusiastically recommended and should prove to be one of the popular textbooks.

F. E. Kunkel

* * * *

MORE YEARS FOR THE ASKING

by

Peter J. Steincrohn, M.D., Chief of Staff, Mt. Sinai Hospital, Hartford, Conn.

218 pages $2.00
New York D. Appleton-Century Co. 1940

(see editorial, page 748)

For Non-Professional Visiting Hours

When the visitors are friends, introduce the Scotch that wins a warm reception—mellow Johnnie Walker.

IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

Red Label
8 years old
Black Label
12 years old
Both 86.8 proof

BORN 1820
... still going strong

CANADA DRY GINGER ALE, INC., NEW YORK, N. Y.
SOLE IMPORTER

SILVER PICRATE
Wyeth
is indicated in the treatment of

★ Acute Anterior Urethritis (due to Neisseria gonorrheae)
★ Trichomonas Vaginalis Vaginitis
★ Vaginal Moniliasis
★ Bartholinitis and Skeneitis (due to Trichomonas Vaginalis)

Silver Picrate is a definite crystalline compound of silver and picric acid. Available in the form of crystals and soluble trituration for the preparation of solutions; suppositories; water-soluble jelly; and powder for insufflation.

Complete information mailed on request

★ JOHN WYETH & BROTHER, INCORPORATED ★
PHILADELPHIA, PA.

THE 1940 YEAR BOOK OF RADIOLOGY

Edited by
Charles A. Waters, M.D., Associate in Roentgenology, Johns Hopkins University.
Whitmer B. Firor, M.D., Assistant in Roentgenology, Johns Hopkins University
Ira I. Kaplan, B. Sc., M.D., Director, Radiation Therapy Department, Bellevue Hospital, New York City; Clinical Professor of Surgery, New York University Medical College

496 pages $5.00
Chicago The Year Book Publishers, Inc. 1940

This book, as in other years, is about equally divided between diagnosis and therapy. Its usual high standard of excellence has been maintained this year although approximately 10 per cent less of the material in this edition is from foreign sources as compared with last year, due to the war in Europe. As stated by one of the editors, little of value has been published abroad on irradiation therapy during the past year. Prophylactic iradiation in the treatment of infections, however, has been found to be of value in getting the wounded soldiers back to duty more quickly, decreasing the percentage of infection by streptococcic, staphylococcic and gas-forming organisms

Material from American sources, as in other years, has been adequately treated, although here again there is little new in irradiation therapy. One of the editors (Kaplan) has written a special article of interest on the x-ray therapy of amenorrhea and sterility. Another special article on preoperative irradiation in the treatment of renal tumors has been included by Waters. Several new diagnostic procedures have been reported during the past year, one of the most interesting dealing with the injection of opaque material into the shoulder joint to diagnose ruptures of the adjacent tendons.

The book is very well illustrated. It should be an invaluable reference book, particularly for the radiologist, but also for other physicians.

W. C. Hall

* * * *

SYNOPSIS OF THE PRINCIPLES OF SURGERY

by
Jacob K. Berman, M.D., F.A.C.S., Assistant Professor of Surgery, Indiana University School of Medicine

615 pages $5.00
St. Louis C. V. Mosby Co. 1940

This book is a well rounded and orderly synopsis of the principles of surgery. The chapters have broad headings and the subject is covered from an historical review down through the various systems, pathology, physiology, biochemistry and the gamut of surgical conditions with their manifestations and treatments.

In the author's words, "the body of the book carries the 'conquered ground' of surgical diseases whereas the footnotes carry the correlated facts . . . and even the unconquered fields." The volume is indexed and the references are copious. Illustrations, photographs and diagrams are abundant and enlightening.

B. Dodd

The Connecticut State Medical Journal

, . INDEX . .

Volume IV January - December, 1940

A

Abstracted Papers:
  Blast Injury to the Lungs......x, 603
  Body Protection for the Soldiers......x, 621
  Method of Nutritional Protection during the Senescence......xi, 706
  Modern Treatment of Pneumonia. T. S. Evans, M.D......vii, 400
  Achilles Heel, The......Ed......i, 32
Acute Laryngotracheobronchitis. P. B. McCready, M.D......iii, 123
Allantoin, — A Possible Leucocytosis Producing Factor. F. R. Greenbaum, D.Sc......ix, 546
Allergy in General Practice......J. S. Harris, M. D.......viii, 437
Alpha and Omega......Ed......ix, 527
American Medical Association — New Haven, 1860......Creighton Barker, M.D.......vi, 319
A. M. A. Convention......vii, 409
American Federation of Labor and Health Insurance......R. J. Watt......vi, 322
American Red Cross — Harvard Study Unit......Ed......x, 609
American Red Cross......xi, 690
Annual Reports, Conn. State Medical Society......v, 285; vii, 423; ix, 539
Annual Meeting, 148th......iv, 214; v, 245
Annual Meeting, 1940......Ed......iii, 154; vi, 356
Association of Tumor Clinics:
  Fourteenth Meeting, Lawrence & Memorial Hospitals New London......iii, 142
  Fifteenth Meeting, Waterbury......iv, 208
  Sixteenth Meeting, Meriden......vi, 338
  Seventeenth Meeting, New Haven......viii, 454
Attention — Advertisers......Ed......i, 31
Aviation Medicine Today......Wm. B. Smith, M.D......x, 595

B

Begg, Doctor Alexander S......Ed......xi, 677
Beginnings of Medical Practice in New Haven Colony......H. Thoms, M.D......xi, 639
Birthday......Wm. Beaumont, M.D.....Ed....xi, 677

C

Can Diabetes Be "Cured" by Early, Vigorous Treatment?......L. T. McDaniel, M.D., A. Marble, M.D., and E. P. Joslin, M.D......xii, 710
Care of the Premature Infant..... Ed......xii, 746
Cause and Effect......Ed......ii, 102
Charter and By-laws, Conn. State Medical Society......viii, 492
Chemotherapy with Sulfonamide Derivatives......Ed......iv, 216
Child Guidance......George K. Pratt, M.D......xii, 739
Clinical Congress, 16, Program of......vii, 420
Connecticut Clinical Congress......Ed......ii, 102
Connecticut Clinical Congress, Retrospect......M. J. Strauss, M. D......xi, 678
Clinical Problems in the New born Infant..... H.H. Gordon. M.D......iv, 191
Cloonan, J. J., M.D......Obit......iii,178
Collateral Circulation of the Heart......L. H. Nahum, M.D......v, 259

CATALOGUED
FEB 5 1941
F. K. M.

BOSTON MEDICAL LIBRARY
FEB 5 1941

30223

C

Common Sense in Psychiatry......C. C. Burlingame, M.D......xii, 735
Congenital Arteriovenous Fistulas, with Report of Two Cases......B. B. Landry, M.D......ii, 64
Connecticut Hospital Association, Enter......Ed......i, 30
Connecticut Hospital Association.....i, 34;.....iv. 224;.....v, 281;.....vii, 411;.....viii, 482;.....x, 614;..... xi, 682;.....xii, 760
New England Institute for Hospital Administrators.....iii, 159
Opening of New Institution for Mental Defectives at Southbury.....E. H. Roselle, Supt.....xi. 684
Connecticut Medical Examining Board......Ed......xii, 748
Connecticut Prepares......S. H. Wadhams, M.D......x, 588
Connecticut Way, The......J. L. Linde, M.D......viii, 443
Connecticut and the Nation's Defense......Ed......viii, 477
Controlled Physically Induced Fever......Wm. B. Shaw, M.D......ii, 88
Cortico-Sterone, Its Clinical Uses......P. Lavietes, M.D......v, 265
Crystalline Zinc Insulin with Protamine......B. Greenhouse, M.D......ii, 78

D

Dean Blake......Ed......vi, 357
Diagnosis and Treatment of Patients with Low Metabolism......E. F. Gildea, M.D......v, 261
Digitalis U.S.P. XI......A. J. Geiger, M.D......vi, 331
Diseased Cervix As a Cause of Symptoms in Women......H. B. Perrins, M.D......xii, 741
Dissecting Aortic Aneurysm......W. H. Lowell, Jr., M.D......xii, 724
Doctors of Dental Medicine. A New Product at Harvard......Ed......ix, 526
Doctor Burt Presides......Ed......x, 609
Doctor Higgins: Half a Century in Medicine......Ed......ix, 525
Doctor Horning Resigns......Ed.......vii, 404
Doctors Office, The......iv, 233;......vii, 410;......ix, 535......; x, 626;......xi, 669;......xii, 763.
Dysmenorrhea......Carl E. Johnson, M.D......i, 20

E

Early Days of the Fairfield County Medical Association......W. M. Stahl. M.D......xii, 732
Economic and Social Aspects of Diabetes......Ed......ii, 103
Elmcrest Manor Offers New Facilities......Ed......ix, 527
Emergency Treatment of Fractures......C. R. Murray, M.D......xi, 645
Endometriosis......E. A. Herr, M.D......vii, 389
Etiology of Cancer in Man in Light of Animal Experimentation.....Wm. Cramer, M.D.....v, 254

F

Famous First, A......Ed......iii, 153
Federal Grants......Ed......i, 31
Ferris, H. B., M.D......Obit......xi, 699
Focal Infection......J. R. Paul, M.D......iv, 198
From the Secretary's Office......Creighton Barker, M.D......i,33;......ii, 107;......iii, 156......iv, 223;...... v, 278;.....vi, 361;.....vii, 407.....viii, 480;......ix, 529;.......x, 611;......xi, 679;......xiii, 752
From Peace to War......Ed......x, 607
Further Studies in Therapy of Acute Anterior Poliomyelitis......C. L. Thenebe, M.D. and M. S. Hirschberg, M. D. ......i, 25
Fundamental Principles of Treatment of Gonococcal Infections in Women......R. M. Lewis, M.D......xi, 662
Future Progress......A. B. Landry, M.D......iv, 185
Ferris, H. B., M.D......Obit......xi, 699
Four Score and Ten — Plus Ten......Ed......xii, 748

G

General Practitioner's Forum......i, 40;......ii, 110;......iii, 167;......iv, 227;......v, 284;......vi, 366;.... vii, 417;......viii, 485;......ix, 535;......x, 627;......xi, 691
Get Off the Cracker Barrel.....Ed......xii, 745
God of War Calls, The......Ed......vi, 359
Graduate Medical Students Problem, The......Ed......viii, 477
Greatest of All Gifts......Ed......iii, 153

H

Handbook of Cancer, The......Ed......iv, 221
Hartford Once Again......Ed......v, 273
Hawley, George W.......Obit......iii, 176
Health Officer of Today, The......Ed......iv, 221
Health of Our Children, The......Ed......vi, 357
Health for Pupils and Teachers......I. V. Hiscock, Sc. D......ix, 509
Hewes, F. W......Obit......vii, 433
Hewitt, A. F......Obit......ii, 116
Hugh Cabot, Salesman......Ed......v, 277

I

Increasing Importance of Preventive Industrial Medicine......A. S. Gray, M.D......x, 600
Industrial Health, Section on......vii, 417
Industrial Medicine of Tomorrow......C. Kuh, M.D......ii, 94
Industrial Pathogenesis......Ed......i, 29
Industrial Poisons......Physiological and Pathological Considerations......Geo. H. Gehrman, M.D......i, 3
In Restraint of Trade......Ed......iv, 217
Intestinal Intubation......C. H. Duston, M.D......iv. 187
In What Cases Should One Employ Protamine Insulin?......Paul Lavietes, M.D......v, 264
Is There an Iodine Fast State?......Paul Lavietes, M.D......v, 266
It Can Happen Here......Ed......iv, 218

L

Lady Drivers.....(For Home Consumption)......Ed......x, 610
Late Season Cold, The......Ed......iv, 219
Legg-Perthe Disease with Particular Regard to Treatment......M. M. Pike, M.D......i, 5
Letters to the Editor......i, 48;.....iii, 171;.....iii,172;.....iv, 232;.....vii, 428;.....viii, 481;.....xii, 763
Lynch, John Francis......Obit......xii, 776

M

Medical Aspects of Deep Sea Diving......C. W. Shilling, U.S.N......x, 597
Medical Necromancy......Ed......i, 30
Medicine and Medical Care in the Defense Program......Gov. R. E. Baldwin......x, 586
Medical Profession Prepared for New Conscription Act......x, 625
Medical Preparedness in Connecticut......Creighton Barker, M.D......ix, 513
Medical Preparedness......Ed......x, 606
Medical Preparedness......xii, 764
Medical Preparedness in Other States......x, 623
Message From The President......A. B. Landry, M.D......vi, 313;......x, 605
Military Medicine Number of Other Journals......Ed......x, 610
Modern Methods in Treatment of Pneumonia......C. S. Keefer, M.D......iii, 131
Modern Treatment of Pneumonia......T. S. Evans, M.D......vii, 400
More Light on Cancer......Ed......v, 274
Murphy, James E.......Obit......i, 50

N

National Health Legislation......Ed......vii, 402
National Health Program, A Front For Socialism......(Reprinted)......ix, 533
National Hearing Week......Ed......x, 609
National Physicians Committee......Ed......v, 276
National Conference on Medical Preparedness......x, 619
Neuro-Psychiatric Inst. of the Hartford Retreat: Report......vi, 363......vii, 418
New England Conference on Tomorrow's Children.....Caroline Ruutz-Rees,,,,,,xii, 768
New Health Insurance Bill-Redrafted by American Association for Social Security......Ed......ii, 108
New Haven Hospital Revolutionizing Operating Room Policies......Ed......ix, 528
News from County Associations......i, 42;......ii, 112;......iii, 169;......iv, 229;......v, 301;......vi, 367; vii, 427;......viii, 487;......ix, 537;.....x, 628;......xi, 692;......xii, 771
News from Yale University School of Medicine......xi, 669;......xii, 774
Nolan, Daniel A., M.D.......Obit......xi, 700

O

Obstetric Aspects of Prematurity......E. L. Stone, M.D......vi, 326
Occupational Dermatoses from Viewpoint of the General Practitioner......J. G. Dowling, M.D......ii, 96
Organization of Medical Services for the Care of Civilians Injured in Air Attacks.....Ebbe Hoff, Ph.D......ix 501
Orthopedic Surgery, Section on......3, 166;......7, 415
Our Greetings to Two New Journals......Ed......viii, 478
Our Neighbors......i, 41;......ii, 111;......iii, 168;......iv, 228;......vi, 367;......vii, 427;......viii, 486;......
ix, 536;......x, 627;......xi, 692;......xii, 771
Our Younger Brother......Ed......iii, 154

P

Pasuth, B. C......Obit......iv, 238
Periodic Health Examinations in the Prevention of Cancer......Ed......xi, 676
Peters H. LeB......Obit......ix, 547
Physiology of Aviation and Medical Preparedness......J. F. Fulton, M.D......x, 590
Placental Blood Bank......S. Spinner, M.D......vii, 387
Plea for Conservatism......Ed......viii, 475
Pneumo-Myelography in Diagnosis of Spinal Cord Lesions......B. S. Brody, M.D......vi, 337
Pregnancy Complicated by Cancer of Cervix......A. H. Morse, M.D......xii, 743
Premarital Examinations......Ed......v, 276
Premonitory Symptoms of Acute Coronary Thrombosis.....E. Gipstein, M.D......v, 270
Prepaid Medical Service......Creighton Barker, M.D......iv, 200
Present Trend in Treatment of Progressive Deafness......Norton Canfield, M.D......i, 12
Preservation of Serviceable Hearing......Ed......xii, 747
President's Plan for New Hospitals......Ed......iii, 152
Problem of Low Back and Sciatic Pain......Ed......v, 274
Problem of Lung Abscess......Ed......ii, 101
Problems of Obstetric Practice in Rural Areas of the United States......E. F. Daily, M.D......ii, 69
Problems Relating to Diphtheria Toxoid Immunization......M. M. Hillman, M.D......xi, 664
Proposed Changes Connecticut Medical Practice Act......xii, 756
Proceedings, Annual Meeting, House of Delegates......ix, 539
Proctology, Section on......iii, 166;......iv, 227
Programs — Semi-Annual County Association Meetings......x, 613
Prophylactic Removal of Rectal Polyps......S. B. Kleiner, M.D......v, 269
Psychiatric Approach to Problems in General Medicine......J. H. Wall, M.D......iii, 127
Public Health Program......Ed......iii, 151

Q

Quarto Notes (Book Reviews)......i, 50;......ii, 118;......iii, 179;......iv, 239;......v, 306;......vi, 372;......
vii, 433;......viii, 490;......ix, 548;......x, 633;......xi, 701;......xii, 779

R

Radio Cure-Alls......Ed......iv, 220
Ramparts We Watch, The......Ed......ix, 524
Recent Advances in Chemotherapy......Jos. Millett, M.D......ix, 515
Refugee Children in The United States......x, 622
Relation of Pain Relieving Drugs to Respiratory Morbidity......R. M. Waters, M.D......viii, 453
Renal Function in Adrenal Insufficiency......D. C. Darrow, M.D......vii, 393
Renal Hypertension......L. H. Nahum, M.D......v, 259
Renal Stones......C. L. Robbins, M.D......v, 266
Report on Tuberculin Tests in Middletown......M. L. Palmieri, M.D......ii, 87
Results of Four Types of Therapy in 165 Cases of Pneumonia......P. J. Steincrohn, M.D......xi, 653
Results in Treatment of Epileptics with Sodium Diphenyl Hydantoinate (Dilantin).....M. E. Brodsky, M.D......et
al......vii, 385
Revised Nurse Practice Act......A. K. Ohlson, R.N.....ii, 63
Roster of Members......ix, 551

S

Schonlein-Henoch's Purpura Simulating Acute Surgical Abdomen......J. B. Herrman, M.D......iv, 202
Semi-Annual County Association Meetings, Programs......x, 613
Sensitive Carotid Sinus......L. H. Nahum, M.D......v, 260
Short Cyclopegia for Refraction......S. J. Beach. M. D......iii, 140
Some Medico-Legal Problems......A. F. Mignone......xii, 719
Smith, E. H., M.D......Obit......v, 306
Specific Versus Mixed Therapy in Vitamin B Deficiency..... M. Heinemann, M.D .....v, 263
State Department of Health:
  Connecticut Mortality in 1939......Wm. C. Welling......iv, 212
  Efficiency of Serological Tests for Syphilis in Connecticut......F. L. Mickle Sc. D. and E. K. Borman, M.S. ......viii, 471
  Periodic Health Examination, The...... M. H. Griswold, M.D......viii, 471
  Some data on Reported Cases of Syphilis and Gonorrhea in Connecticut during 1939......H. P. Talbot, M.D ......iii, 148
  What The Family Physician may expect from the Public Health Nurse......H. V. Dudley, R.N......xi, 672
State of our Health......Ed......xi, 676
Stop and Think......Ed......xi, 674
Stratton, E. A., M.D......Obit......ii, 116
Summary of Gynecological and Obstetrical Papers......J. Fraser, M.D......i, 23
Swain, H. L., M.D......Obit......ii, 61

T

That Secondary Adenoid and Tonsil Operation......W. H. Turnley, M.D......viii, 447
Therapeutic Aids in Otolaryngology......F. W. Sperry, M.D......ii, 74
Treatment of Bacterial Endocarditis......Ed......vi, 358
Treatment of Compound Fractures......D. C. Patterson, M.D......xi, 666
Treatment of Gonococcal Salpingitis and Arthritis with Sulphanilamide......R. M. Lewis, M.D......vi, 335
Treatment of Pneumonia......L. H. Nahum, M.D......iii, 135
Treatment Procedures for Cancer of the Uterus, Advised by Conn. Tumor Clinics......J. R. Miller. M.D.....i, 16
Trichinosis......George Blumer, M.D......vi, 314
Tumors of Lateral Aberrant Thyroid Tissue, Report of 2 Cases......W. A. Geer, M.D......xi, 670

U

Uncle Sam Counts Noses Again......Ed......ii, 106
United States Pharmacopeial Convention......Ed......iv, 222
Unusual Case of Pancreatic Abscess......P. J. Steincrohn, M.D......viii, 450
Use of Tobacco, The......Ed......xi, 675

V

Virus Pneumonia......S. Bayne-Jones, M.D......v, 258
Vitamin Deficiencies with Special Reference to Those Involving the Nervous System......E. F. Gildea, M.D......ii, 83
Vitamin in Bleeding Diseases......M. Heinemann, M.D......v, 262
Vulvovaginitis in Children......Louis Newton, M.D. and M. S. Popkin, M.D......vii, 395

W

War Times Are Strange Times......Ed......ix, 527
What Is Renal Clearance?......R. W. Clarke, Ph. D......v, 256
What Is a Neurosurgical Emergency?......W. J. German, M.D......vii, 398
What Do People Need For Their Health and Medical Care?......H. Emerson, M.D......vii, 377
What Others Think About Our Cancer Handbook......Ed......vii, 405
Whiteside, G.S......Obit......iv, 238
Who Hath Desired the Sea?......Ed......xi, 674
Wolfe, R. M......Obit......iii, 177
Work Beside Work......Ed......vii, 402
Wilson, Leo......Obit......xii, 776

Z

Zinsser, Hans......Obit......S. Bayne Jones, M.D......x, 632

. . INDEX . .

Volume IV

January - December, 1940

B

Barker, Creighton......Prepaid Medical Service......iv, 200
    American Medical Association, New Haven, 1860......vi, 319
    Medical Preparedness in Connecticut......ix, 513
Bayne-Jones, Stanhope......Virus Pneumonia......v, 258
Beach, S. J.......Short Cyclopegia for Refraction......iii, 140
Blumer, George......Trichinosis......vi, 314
Brodsky, M. E......Results in Treatment of Epileptics with Sodium Diphenal Hydantoinate (Dilatin)......vii, 385
Brody, B. S.......Pneume-Myleography in Diagnosis of Spinal Cord Lesions......vi, 337
Burlingame, C. C......Common Sense in Psychiatry......xii, 735

C

Canfield, Norton......Present Trend in Treatment of Progresssive Deafness......i, 12
Clarke, R. W......What is Renal Clearance?.....v, 256
Cramer, Wm......Etiology of Cancer in Man in light of animal experimentation......v, 254

D

Daily, E. F......Problems of Obstetric Practice in Rural areas in the U. S......ii, 69
Darrow, D. C......Renal Function in Adrenal Insufficiency......vii, 393
Downing, J. G......Occupational Dematoses from the Viewpoint of the General Practitioner......ii, 96
Dudley, Hazel V......What the Family Physician May expect from the Public Health Nurse......xi, 672
Duston, C. H......Intestinal Intubation......iv, 187

E

Emerson, Haven......What do People Need for Their Health and Medical Care?......vii, 377
Evans, T. S......Modern Treatment of Pneumonia......vii, 400

F

Fraser, John......Summary of Gynecological and Obstetrical Papers......i, 23
Fulton, John F......Physiology of Aviation and Medical Preparedness......x, 590

G

Geer, W. A......Tumors of Lateral Aberrant Thyroid Tissue......xi, 670
Gehrmann, G. H......Industrial Poisons, Physiological and Pathological Considerations......i, 3
German, W. J......What is a Neurosurgical Emergency?......vii, 398
Geiger, A. J......Digitalis U. S. P......xi.....vi, 331
Gildea, E. F......Diagnosis & Treatment of Patients with low Metabolism......v, 261
Gipstein, Edward......Premonitory Symptoms of Acute Coronary Thrombosis......v, 270
Gordon, H. H......Clinical Problems in the Newborn Infant......iv, 191
Gray, A. S......Increasing Importance of Preventive Industrial Medicine......x, 600
Greenhouse, Barnett......Crystalline Zinc Insulin with Protamine......ii, 78
Griswold, M. H......The Periodic Health Examination......viii, 471

H

Harris, J. S......Allergy in General Practice......viii, 437
Heinemann, M......Vitamin K in Bleeding Diseases......v, 262
    Specific versus Mixed Therapy in Vitamin B Deficiency......v, 263
Herr, E. A......Endometriosis......vii, 389
Herrmann, J. B......Schonlein-Henoch's Purpura Simulating Acute Surgical Abdomen......iv, 202
Hillman, M. M......Problems Relating to Diphtheria Toxoid Immunization......xi, 664
Hirschberg, M. S......Further Studies in Therapy of Acute Poliomyelitis......i, 25
Hiscock, I. V......Health for Pupil and Teacher ......ix, 509
Hoff, Ebbe......Organization of Medical Services for the Care of Civilians Injured in Air Attacks......ix, 501

J

Johnson, C. E......Dysmenorrhea......i, 20

K

Keefer, C. S......Modern Methods in Treatment of Pneumonia......iii, 131
Kleiner, S. B......Prophylactic Removal of Rectal Polyps......v, 269
Kuh, Clifford......Industrial Medicine of Tomorrow......ii, 94

L

Landry, A. B......Future Progress......iv, 185
    Message From the President......x, 605
Landry, P. B......Congential Arteriovenous Fistulas with report of 2 cases......ii, 64
Lavietes, Paul......In What Cases should one employ Protamine Insulin?......v, 264
    Cortico-Sterone, Its Clinical Uses......v, 265
    Is There an Iodine Fast State?......v, 266
Lewis, R. M......Treatment of Gonococcal Salpingitis and Arthritis with Sulphanilamide......vi, 335
    Fundamental Priniciples of Treatment of Gonococcal Infections in Women......xi, 662
Linde, J. I......The Connecticut Way......viii, 443
Lowell, W. H. Jr......Dissecting Aortic Aneurysm......xii, 724

M

Machready, P. B......Acute Laryngotrachebronchitis......iii, 123
McDaniel, L. T. (with A. Marble and E. P. Joslin)......Can Diabetes Be "Cured" by Early, Vigorous Treatment? ......xii, 710
Mickle, Friend Lee (with Borman, Earle K.)......Efficiency of Serological Tests for Syphilis in Connecticut.....vi, 351
Mignone, A. F......Some Medico-Legal Problems......xii, 719
Miller, J. R.......Treatment Procedures for Cancer of the Uterus advised by the Connecticut Tumor Clinics.....i, 16
Millett, J......Recent Advances in Chemotherapy......ix, 515
Murray, C. R......Emergency Treatment of Fractures......xi, 645
Morse, A. H......Pregnancy Complicated by Cancer of Cervix......xii, 743

N

Nahum, L. H......Treatment of Pneumonia......iii, 135
    Renal Hypertension......v, 259
    Collateral Circulation of the Heart......v, 259
    Sensitive Carotid Sinus......v, 260
Newton, L......Vulvovaginitis in Children......vii, 395

O

Ohlsen, A. K.......The Revised Nurse Practice Act......ii, 63

P

Patterson, D. C......Treatment of Compound Fractures......xi, 666
Paul, J. R......Focal Infection......iv, 198
Perrins, H. B......Diseased Cervix as Cause of Symptoms in Women......xii, 741
Pike, M. M......Legg-Perthe Disease with Particular Regard to Treatment.....iv, 5
Pratt, G. K......Child Guidance......xii, 739

R

Robbins, C. L.. . . Renal Stones......v, 266
Ruutz-Rees, C.... . New England Conference on Tomorrow's Children......xii, 768

S

Shilling, C. W......Medical Aspects of Deep Sea Diving......x, 597
Smith, W. B......Aviation Medicine Today......x, 595
Snow, W. B......Controlled Physically Induced Fever......ii, 88
Sperry, F. N......Therapeutic Aids in Otolarngology......ii, 74
Spinner, S......Placental Blood Bank......vii, 387
Stahl, W. M......Early Days of the Fairfield County Medical Association.....xii, 732
Steincrohn, P. J......Unusual Case of Pancreatic Abscess.....viii, 450
Results of Four Types of Therapy in 165 cases of Pneumonia.....xi, 653
Stone, E. L......Obstetric Aspects of Prematurity......vi, 326
Strauss, M. J......Clinical Congress 1940 — Retrospect......xi, 678

T

Talbot, H. P......Some Data on Reported cases of syphilis and gonorrhea in Conn. during 1939......iii, 148
Thenebe, C. L......Further Studies in Therapy of Acute anterior poliomyelitis......i, 25
Thoms, Herbert......Beginnings of Medical Practice in New Haven Colony......xi, 639
Turnley, W. H......That Secondary Adenoid and Tonsil Operation......viii, 447

W

Wadhams, S. H......Connecticut Prepares......x, 588
Wall, J. H......Psychiatric Approach to Problems in General Medicine......iii, 127
Waters, R. M.......Relation of Pain Relieving Drugs to Respiratory Morbidity......viii, 453
Watt, R. J......American Federation of Labor and Health Insurance......vi, 322
Welling, W. C......Connecticut Mortality in 1939......iv, 212

47D

LZER
BINDER